An Employee-Owned Company

CHCS MCP USER DESKTOP GUIDE

D/SIDDOMS

CHCS II
COMPOSITE HEALTH CARE SYSTEM

Delivery Order 0134, Development and Alpha Deployment of CHCS Version 4.6, CDRL Item 30

Submitted in Response to:
D/SIDDOMS Contract DASW01-95-D0025,
Expiration Date: [Established via Individual Delivery Orders]
Contract Total Dollar Value: [Established via Individual Delivery Orders]
Delivery Order Total Dollar Value: [Available from DSS-W]

For:

Defense Supply Service - Washington
and Composite Health Care System Program Office
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LIST OF EFFECTIVE PAGES

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RECORD OF CHANGE

This record is maintained throughout the life of the document; each published update is recorded. A Change Package (re-issue of changed pages only) carries change bars in the page margins to identify differences from the preceding issue. Due to the scope of change that necessitates a Revision (re-issue of entire document), a Revision does not carry change bars.

Issue	Date	Summary Description	Reference Data
Draft Update Pages	31 Oct 1997	Build 1 draft CHCS S/W Version 4.6 Change bars highlight updates to documentation.	CHCS-4.6 DO0060, Version 4.6 Design and Development, and DO0062 Management Care Support Contractor (MCSC) Interface. DS-46DV-6035
Alpha Draft	13 Mar 1998	Alpha draft submittal.	CHCS-4.6 DO 134 Development and Alpha Deployment of CHCS Version 4.6.
Final	26 May 1998	Initial submittal.	CHCS-4.61

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MCP

Using This Guide

1. General Overview

This guide is intended as a comprehensive reference manual for Composite Health Care System (CHCS) Managed Care Program (MCP) users.

2. Sections

This guide is organized as follows:

- Introduction
- File and Table Building and Maintenance/Provider Network Functions
- Provider Network Management
- Defense Enrollment Eligibility Reporting System (DEERS) Functions and Processes
- Enrollment Processing
- Managing MCP Patient Appointments
- Interactive Non-Availability Statement (NAS)/Care Authorization Processing
- Appendices.

  These include reference materials, a glossary of terms, an index, and Medicare Demonstration.

2.1 Introduction

Section 1 provides a brief overview of the MCP software, discusses catchment-wide integration of military and civilian health care services, outlines the major MCP software features, and discusses MCP links to DEERS.

In addition, Section 1 discusses security features, system-generated reports and bulletins, mail groups, data entry screens, action bars, and on-line help. Site-specific questions that should be answered prior to MCP activation are listed, and questions often asked by MCP users are listed along with correct answers for each.

Section 1 also provides a summary of the latest MCP software changes.

2.2 File and Table Building and Maintenance/Provider Network Functions

Section 2 discusses file and table building activities that must be completed before MCP enrollment and booking can take place. This section also provides step-by-step instructions for building and maintaining the MCP files and provider network, and for creating primary care managers. Descriptions and samples of major screens are included within the step-by-step instructions.

2.3 Provider Network Management

Section 3 defines the types of providers, i.e., internal, external, network, non-network, exception, and only-service-available providers.

Section 3 also describes each option on the Provider Network Management (PMCP) menu. You are referred back to Section 2 for step-by-step instructions for using the PMCP options to build and maintain a provider network.

2.4 DEERS Functions and Processes

Section 4 explains the interaction between CHCS and the Defense Eligibility Enrollment Reporting System (DEERS). Section 4 topics include performing a DEERS check, enrolling beneficiaries when the DEERS link is down, and resolving data discrepancies between CHCS and DEERS. Descriptions and samples of major DEERS-related screens are included.

2.5 Enrollment Processing

Section 5 discusses the Local Empanelment and DEERS Enrollment modes. Step-by-step instructions are included for all enrollment activities, i.e., enrollment, disenrollment, enrollment renewal, enrollment/disenrollment, cancellation/correction, batch enrollment, conditional and reciprocal enrollment processing. Descriptions and samples of each major screen are included for each Enrollment Processing (EENR) menu and submenu option. Sample enrollment/disenrollment labels, letters, rosters, and reports are provided and explained.

2.6 Managing MCP Patient Appointments

Section 6 provides step-by-step instructions for all appointment booking activities, including displaying patient appointments, appointment cancellation, and printing output products and reports. Sample appointment booking output products and reports are included and explained.

2.7 Interactive Non-Availability Statement (NAS)/Care Authorization Processing

Section 7, Interactive Non-Availability Statement (NAS)/Care Authorization Processing, provides step-by-step instructions for issuing, printing, canceling, and viewing an individual NAS. Instructions for printing a report to a spooled document and printing a spooled document are also included. Sample NAS reports are provided and explained.

3. Addendums

Addendum 1 - Managed Care Support Contract (MCSC) Interface.

This document is not designed to serve as a training manual and is not supported by the CHCS Training Data Base.

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Section 1 Introduction

1. INTRODUCTION

1.1 MCP Overview

The Managed Care Program (MCP) software is designed to assist the Department of Defense (DOD) initiative to:

- Establish TRICARE (Tri-Service Health Care) area-wide health care delivery systems
- Improve accessibility to health care
- Improve cost-effectiveness of health care
- Support the administrative policies of the TRICARE program.

MCP provides an integrated direct care and civilian provider network. It provides premium patient care by allowing patients to enroll in a streamlined network of providers, medical treatment facilities (MTFs), and civilian services.

Those network providers who have agreed to participate in the MCP program offer complete, managed, preventative, routine, and emergency care to TRICARE-enrolled patients.

TRICARE shares some characteristics with commercial managed care, but doesn't directly parallel any managed care network. It most closely resembles a mixed-model health maintenance organization (HMO).

1.1.1 Catchment-Wide Integration

Catchment-wide integration is a term used to describe the DOD requirement to integrate the benefits of a direct care system and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) into a single, coordinated effort under the control of local facility commanders. It contains the following elements:

- **TRICARE Prime** - an HMO option, which enrolls and assigns patients to a primary care manager (PCM). The PCM must authorize all specialty care. Fixed fees are charged per visit, and inpatient care is free, based on beneficiary eligibility. This plan is mandatory for all active-duty personnel in a catchment area and is also available on an elective basis to eligible beneficiaries.

- **TRICARE Extra** - a point-of-service Preferred Provider Option (PPO). At any time, an eligible beneficiary may elect to use a specified network provider. Co-payments are reduced. Both the beneficiary and the Government benefit from lower negotiated rates. Pre-authorization requirements apply for specified procedures and admissions.

- **TRICARE Standard** - fee for service, resembling indemnity insurance. Users are given a full choice of providers, services, and facilities with a slightly higher co-payment and a deductible. Pre-authorization requirements apply for specified procedures and all admissions.

MCP enables the MTF to:

- Assign beneficiaries to selected PCMs

- Establish a military and civilian health care provider network (Provider Network Management)

- Provide beneficiaries with two cost-saving alternatives TRICARE Extra and TRICARE Prime while maintaining the current standard benefits option.

1.1.2 Provider Network Management

The provider network management feature of MCP allows each site to record and maintain searchable records and current information on providers including the following:

- Individual providers
- Military and civilian groups
- Negotiated agreements and discounts
- Defined provider exceptions to negotiated discounts
- Provider schedule availability
- Addresses, phone numbers, and directions to places of care
- Contract compliance controls.

1.1.3 MCP Enrollment

MCP enrollment enables sites to perform the following functions:

- Assign beneficiaries who choose the HMO plan with a PCM, based on specialty, location, and gender preferences
- Check the enrollees' eligibility on the Defense Eligibility Enrollment Reporting System (DEERS)
- Notify DEERS that the beneficiary is enrolled in a specific catchment area (This information is necessary for accurate claims processing.)
- Enroll or disenroll all family members
- Document other health insurance (OHI)
- Identify beneficiaries under case management
- Support administration of TRICARE program policy and regulations.

1.1.4 Patient Care Management

The health care finder (HCF) module of the MCP program is used to identify the provider resources needed to provide required care for a specific patient. It applies to all members; referral and priority requirements differ based on the option selected by the member. It includes the following functions:

- Appointment scheduling for enrolled and non-enrolled patients to military or civilian facilities and PCMs
- Referral processing
- Referral tracking
- Non-network authorizations
- Benefits explanation.

1.1.5 Non-Availability Statement (NAS) Processing

MCP enables the site users to issue NASs for patients who are authorized to seek treatment outside the facility.

A variety of summary and statistical reports are provided to the sites for improved program control. Refer to Section 4.2 for details on available NAS reports.

1.1.6 MCP Links to DEERS

MCP shares information with the external DEERS. DEERS is the central eligibility data base for DOD health care. Eligibility information for MCP is obtained from DEERS; enrollment information is transferred to DEERS from the Composite Health Care System (CHCS), which is the primary enrolling system.

In addition to determining eligibility prior to enrollment or booking functions, the data between the two systems (CHCS and DEERS) is analyzed for discrepancies, and the results are made available for user action. Other information that may affect decisions for enrollment, such as Uniformed Service Treatment Facility (USTF) membership, is submitted to users of MCP.

DEERS checks/updates may be invoked automatically during enrollment or requested by the HCF as needed. Eligibility displays, captured from a DEERS check performed within the last five days, are stored in CHCS and available to MCP users in Enrollment and HCF. Alternatively, the user may request eligibility data as of today. Additionally, MCP users may view or print up to 10 historical DEERS eligibility segments.

> **Note:** DEERS data is protected and cannot be manually changed by the user through the primary operating system. Address data is an exception and can be updated in DEERS through CHCS.

1.1.7 Patient Appointment and Scheduling (PAS) Subsystem

MCP supports the full appointment and scheduling requirements of the facility using the PAS functionality of CHCS. MCP is linked to PAS.

PAS provides a comprehensive system for scheduling and tracking patient appointments. It defines and maintains profiles and schedules for the clinics, divisions, and facilities; performs booking functions; generates management workload and statistical reports; and links the patient's record into all ancillary services of the hospital facilities through automated medical record tracking.

An array of emergency room (ER) programs allows the fast-moving environment of the hospital ER to interface with records and data bases without sacrificing accurate and up-to-date data.

Disposition processing options and check-out and patient instructions options within this segment make this ER functionality self-contained. End-of-day (EOD) processing is also a part of this module, assuring that the scheduled activity for each day is processed to completion.

Additionally, the menu provides a full interface to the registration options, allowing the ER to independently handle all incoming patients.

1.2 MCP Menu Assignments

The following guidelines, FileMan access codes, and security keys are used to assign menus to MCP users:

1.2.1 MCP F/T POC - Systems Manager Menu (EVE) Restricted

Primary Menu Option:	Managed Care Program Menu [MCP MAIN MENU]
Secondary Menu Options:	Menu Management Menu [XUMAINT]
FileMan Access Codes:	#SsA
Security Keys:	CPZ CCP CPZ NET CPZ FILE CPZ AGRMOD CPZ ADHOC

1.2.2 MCP HCFs

Primary Menu Option:	Managed Care Program Menu [MCP MAIN MENU]
Secondary Menu Options:	End-of-Day Processing/Editing [SD EOD EDITING] Operational Reports Menu [SD OPER REPORTS]
FileMan Access Codes:	&s
Security Keys:	CPZ MCP CPZ CASE CPZ NAS CPZ PCM LABEL
Clinic Access (PAS Booking Keys):	SD (BOOKING AUTHORITY) SD (CHANGE AUTHORITY) SD (OVERBOOK AUTHORITY)

1.3 FileMan Access

FileMan access security protects some files and fields within the files. The user must have one of the file access codes assigned in the User file record to read, write, delete, copy, or add (using Learn As You Go – LAYGO) to the file.

Each subsystem within CHCS has specific FileMan access codes. Generally, uppercase codes specify supervisor access and permit both read and write access. Lowercase codes specify standard user access and usually permit read-only access. Each subsystem defines the use of the related code.

Refer to Table A-1 in Appendix A, for the Common, PAS, and MCP files and the associated FileMan access codes needed to read, write, or LAYGO into each file. Note that only one of the codes specified is needed for access. After a FileMan access code has been added or edited, the user must perform a restart session to initiate the new access codes.

1.4 Security Keys

In addition to the protection provided by FileMan access codes, several security keys control access to MCP menu options. These keys must be assigned to authorized users by a site system manager. Refer to Table A-3 in Appendix A, for a description of each MCP security key.

1.5 Scheduled Task Jobs

Several menu options on the Systems Manager Menu (EVE) allow CHCS to automatically generate certain reports and bulletins and to update enrollment transactions. Refer to Section 2.3 TaskMan Options, and Appendix A for additional information.

1.6 MCP/PAS Mailgroups and Bulletins

MCP mail bulletins are system-generated whenever a process occurs or fails to occur (e.g., Batch Enrollments Completed or Batch Reassignment Unsuccessful). These bulletins can be sent to one or more mail groups. Your system manager is responsible for setting up mail groups and attaching bulletins to those groups. Refer to Section 2.4 Mail Bulletins, and Appendix A for additional information.

1.7 Data Entry Screens

Each data entry screen has one or more of the following types of windows:

Display Window	Found at the top of the screen. Usually contains information that is for display purposes and cannot be altered. For appointment booking functionality, the display window usually includes patient demographic information.
Select Window	Found in the middle of the screen. Contains a variety of detail information that varies from screen to screen. For example, the select window often contains a list of possible data elements a user can choose from to search for information in the system or a list of patients to choose from for processing or displaying additional information.
Interact Window	Found at the bottom of the screen. Contains the action bar and occasionally other information.

1.8 Action Bars

An action bar presents a linear display of predefined user choices, or actions. You choose an action by entering the character(s) within the parentheses, then pressing <Return>. The system performs the selected function, then returns control to the action bar.

Default values appear at the end of the action bar prompt, followed by a double slash (//). They may be selected by pressing <Return>. If no default is present, you must choose an action or quit this action bar by pressing either <Q> or a caret <^>, then pressing <Return>.

Three kinds of help can be requested at an action bar:

- A single question mark (?) requests general application help. This may, optionally, be followed by detailed help.
- When available, a single question mark followed by valid input (e.g., ?C for (C)hange Search Criteria) requests detailed help for that action. Two question marks (??) request specific information
- Three question marks (???) request the Online User Manual (OLUM).

1.9 Accessing Online Help

You can access four kinds of online help in CHCS:

- A single question mark (?) entered in a field or at a prompt requests general application help. This may, optionally, be followed by detailed help.
- When available, a single question mark followed by valid input (e.g., ?C for (C)hange Search Criteria) requests specific detailed help for the specified action.
- Two question marks (??) entered in a field or at a prompt provide specific information about the data required for valid entries at that field or prompt. Two question marks entered at an action bar provide specific information about that action bar.
- Three question marks (???) entered in a field or at a prompt request the OLUM. Three question marks at a menu option prompt display a brief description of each option on that menu.

1.10 OLUM

The OLUM is a comprehensive user's manual that covers all CHCS functionalities, the system, MailMan, and FileMan ad hoc reporting options. OLUM provides the menu hierarchy, functional descriptions, step-by-step instructions for each option, and sample screens and reports.

1.11 Site-Specific Questions That Should Be Answered Prior to MCP Activation

- Who are the PCMs? Are they individual providers or provider groups? Are they military or civilian?
- Who are the NAS issuing officers?
- Will enrollment be restricted to only those patients residing within the catchment area?
- Do non-MTF places of care require patient and radiology records to be pulled?
- How will the HCF receive referrals from the PCMs?
- How will the HCF receive instructions to modify the referrals; e.g., increase the number of authorized visits?
- How will the PCM notify the HCF that an enrolled patient is now a case management patient?
- Who does the HCF notify if a patient must be assigned to a case manager who does not appear in the system?
- Who does the HCF notify if OHI patient information must be added for a new insurance company that does not appear on the system?
- What appointment types are accepted by civilian network providers?
- How will enrollment forms, care authorization forms, and NAS forms be handled for each patient at this facility? For instance, will they be mailed to the patient, or filed in each patient's records?

1.12 Other Questions MCP Users Often Ask

- Can any file be modified?

Answer: No. Standard files are installed with all entries complete. They cannot be modified by the site (i.e., DOD standard files). This guide discusses those files that can be modified.

- Does a new HCF need to be assigned to an MCP office?

Answer: Yes. When you add a new HCF to the Health Care Finder file, you must specify an MCP office so the proper HCF information displays on the care authorization form.

- If enrollment is restricted to only those patients residing within the catchment area, can a patient who resides outside the catchment area be enrolled?

Answer: If you hold the CPZ ZIP security key, you are prompted to override the restricted enrollment and can proceed with the patient's enrollment. If you do not have this security key, the prompt does not display and you cannot enroll the patient.

- What four flags must be set to YES in order to activate a provider group as a PCM?

Answer: Actually, only three flags must be set to YES in order to activate a provider group as a PCM:

1. The Activate Provider Group field on the Provider Group Profile screen 1.

2. The field under the PCM heading that confirms the specialties associated with the group. To access this field, choose the Edit action on the action bar for the Individual Provider Profiles screen, then select the Group Provider to edit. After you confirm the information on the Group Profile screen and exit the Place of Care field, you can set the field under the PCM heading to YES.

3. The Activate Group PCM field on the Provider Group PCM Capacity screen. To access this field, choose Enrollment Mix on the Agreements action bar, then select the agreement type(s) for which the provider will be serving as a PCM.

   A fourth flag, when set to YES, activates an individual provider within the group as a PCM. If only the group is to be a PCM and not the individual providers, this flag is not required.

- When entering a new agreement for a provider group, where does the user obtain the fiscal intermediary (FI) notified date?

Answer: The Contracts staff normally provides this information.

- What prevents a PCM from displaying on a picklist during a PCM search when you know that the PCM is supposed to be there?

Answer: The PCM search process is very specific and all search criteria must be exact. If the wrong specialty or location is entered or if the PCM is not defined correctly with all flags, the PCM name does not appear.

- What is the difference between CHCS registration, DEERS registration, and MCP enrollment?

Answer:

CHCS Registration

CHCS registration enters a beneficiary into the local CHCS system using the Mini Registration or Full Registration option. Full registration is usually only used for inpatient admission to an MTF.

DEERS Registration

DEERS registration enters a military beneficiary into DEERS so that the patient can receive military health care benefits. Enrollment takes place at the military base, not on CHCS.

Any time a beneficiary's name is entered into CHCS, CHCS queries the DEERS data base to ensure the beneficiary is eligible to receive military health care benefits.

If the beneficiary receives care outside the MTF and submits a CHAMPUS claim, an FI checks the DEERS data base to ensure that the beneficiary is eligible to receive CHAMPUS reimbursement benefits.

MCP Enrollment

MCP enrollment enrolls a beneficiary in the TRICARE program using the MCP Enrollment option on CHCS. A beneficiary voluntarily enrolls in this alternative health care delivery system instead of receiving the standard military health care benefits package. The beneficiary is assigned to a PCM, who provides primary care and makes referrals to specialists when medically appropriate.

- What is the difference between Local Empanelment mode and DEERS Enrollment mode?

Answer:

Local Empanelment Mode

Local Empanelment mode allows a site to conduct managed care activities locally without changing the Alternate Care Value (ACV) of the non-active-duty beneficiaries on the DEERS data base. Using local empanelment, non-active-duty beneficiaries receive

a PCM and other managed care activities, as well as the standard CHAMPUS benefits. The MCP beneficiary enrollment information is not sent to DEERS, although standard CHAMPUS eligibility information is available from DEERS. In many regions, the contractor system uses local empanelment in CHCS in conjunction with full enrollment in DEERS so that both CHCS and the Managed Care Support Contractor (MCSC) systems have enrollment data.

Note: In Local Empanelment mode, the system sends enrollment and disenrollment transactions to DEERS for active-duty beneficiaries, as in the DEERS Enrollment mode.

DEERS Enrollment Mode

The DEERS Enrollment mode allows a site to formally conduct managed care activities. The system sends enrollment and disenrollment transactions to DEERS, changing the ACV and Defense Medical Information Systems Identification (DMIS ID) of the beneficiaries. The FI can view the ACV, and thereby the enrollment status, for a beneficiary when processing CHAMPUS claims. Full enrollment may include changes to the standard CHAMPUS benefits and enrollment fees, depending upon managed care policies set by Health Affairs. Full enrollment using CHCS also documents the MTF (DMIS ID) where the beneficiary receives primary care.

- What is the difference between an MTF provider, an external provider, and a non-network provider?

Answer:

MTF Provider

MTF providers are both military and civilian. The civilian providers have partnership agreements to provide care within the MTF. Whenever possible, MTF providers are used.

External Provider

External providers are civilians with agreements to deliver health care, at discounted rates, to Military Health Service System (MHSS) beneficiaries at the provider’s place of care.

External providers are used when military care is unavailable. The agreements with external providers are negotiated to obtain the highest quality services for the lowest rates.

Non-Network Provider

A provider who is not a member of the network; i.e., has not signed a network agreement and does not offer a negotiated discount for services. Exception and only-service-available providers are non-network providers.

Exception Provider

A provider who is not a member of the network but who has been identified to give specialized treatment to an enrolled patient, since this provider has previously provided care for a patient and disruption of that care would be detrimental to the patient.

A non-MCP provider group can be created for the exception provider.

Only Service Available (OSA) Provider

A provider who offers a specialty or service unique to the area. OSA providers can be exception providers. They appear on picklists when searching by specialty and location.

- Can you search for a specific clinic in non-enrolled booking?

Answer: Yes, if the clinic is defined as a provider group. The software does not currently include "clinic" as search criteria. After the search criteria are entered, Provider Search displays as an action on the Non-enrolled Booking action bar. Once you select Provider Search, the system allows you to search for a specific provider, MTF provider only, external network provider, and/or non-network provider. The Clinic field displays on the Non-Enrolled Booking Search Criteria screen after the provider is selected from a picklist.

- Is the appointment type required for provider searches?

Answer: No. But if you leave the field blank, depending on the type of search you have selected, a list of providers displays that matches the referral regardless of the appointment types assigned to them. The list shows the first available appointment for any appointment type.

Entering an appointment type for an MTF provider search excludes providers without schedules but displays the MTF provider that meets the search criteria along with the first available appointment date.

- What prevents a provider from displaying on a picklist during a provider search when you know that the provider is supposed to be there?

Answer: The provider search process is very specific and all search criteria must be exact. If the wrong specialty or location is entered, the provider name does not appear. If you enter an appointment type that the provider does not have, the provider name does not appear. Try searching again without specifying an appointment type to see if the provider name appears.

- How do I book to a external network provider using MCP?

Answer: After you have entered the search criteria, select the External action from the Provider Search action bar, and select the provider you want to use. Set up a three-way telephone conference call between the patient, the provider's office, and yourself. When the provider's office and the patient have agreed upon a date and time, add an appointment slot with that date and time, then book the appointment.

- When I book a patient to either an external or a non-network provider, who checks the patient into the provider's office and performs EOD processing?

Answer: Booking to either an external or an non-network provider does not require patient check-in or EOD processing. Once you have booked an appointment to an external or a non-network provider, the appointment status is automatically set to booked, and the appointment displays as booked on the Display Patient Appointment screen.

- Why doesn't the NAS information appear on the NAS History screen right after I issue a new NAS and print it?

Answer: The NAS History screen contains information requested from DEERS at the time you started the session and does not reflect your subsequent actions.

When you quit the History screen and reenter the patient name, the system again requests the NAS History from DEERS and contains the new NAS information. This also occurs when you cancel an NAS.

- Only one place of care displays appointments for the PCM, even though two places of care exist. How can I display all appointments for both clinics?

Answer: You can only enroll to one place of care. Therefore, for a PCM group, only one clinic displays. To display all appointments for all clinics, first build one PAS template with appointment types for one clinic. Then build an MCP group with two places of care and attach providers as PCMs to the group. To give workload credit for the second place of care, at the EOD, assign a Medical Expense and Performance Reporting System (MEPRS) code for the appointment type.

- Why can't I retrieve civilian MTF provider appointments when searching for a non-enrolled booking appointment?

Answer: The system does not contain civilian provider schedules.

- Why are provider schedules for the specialty clinics unavailable for appointment referral booking even though the providers appear in PAS?

Answer: In order for provider schedules for specialty clinics to display during appointment referral booking, the specialty clinic must be identified as an MCP group, and providers must be attached to this group using the Group Profile/Agreements Enter/Edit (GNET) option on the Provider Network Management Menu.

- Can a provider be an individual PCM in two different PCM groups with two different places of care?

Answer: Yes.

- Can a provider be a part of two different PCM groups?

Answer: Yes.

1.13 Summary of CHCS Version 4.6 MCP Changes

- **Enrollment Processing**

Automatically Run the CP Enrollment Bulletin

The system now automatically runs the MCP Enrollment Bulletin and transmits a message to users enrolled in the CPZMGR mail group if the MCP nightly bulletin job does not successfully run to completion. Sites can still manually run the MCP Enrollment Bulletin if required. The system stores enrollment/disenrollment discrepancy codes on the beneficiary record so that the discrepancy report can be manually run at any time.

Compare DEERS Eligibility Data to CHCS Demographic Data

The enrollment process in the Enrollment Enter/Edit (EENR) option has been enhanced to compare DEERS eligibility data to CHCS demographic data during an online eligibility check. The system notifies the user of data discrepancies in date of birth (DOB), sponsor status, and enrollment in another program. The system allows correction of these error(s) during the enrollment process, but does not prevent filing an enrollment if data discrepancies exist.

Conditional Enrollments

In CHCS Version 4.5, eligibility checks and enrollment processing for conditional enrolled beneficiaries was a manual process requiring interactive DEERS eligibility checks. In order to prevent MCP beneficiaries from being disenrolled after 120 days without a DEERS eligibility check, the DEERS check process has been automated.

For conditional enrolled beneficiaries, the system now conducts automatic DEERS eligibility checks in seven-day increments for 120 days after the MCP enroll date. Based on the eligibility response and 120-day conditional enrollment period criteria, the system updates the MCP status.

The system specialist can task the CP Enrollment Bulletin job through TaskMan, as with prior CHCS versions.

MCP clerks and supervisors can still enter conditional enrollments through existing functionality.

DEERS Interactive Eligibility Data Display Enhancements

The existing option to check DEERS eligibility (Menu Path: PAS System Menu → M → EMCP → IENR) has been enhanced to display additional information. You may define the date or date range to check eligibility and enrollment data. If you do not define a start and end date range, the system automatically defaults to the start date of Jan 1, two years prior to the current date, and to the end date of six months into the future. These default dates, however, were not displayed to users. To prevent possible confusion, the system now displays these default dates. Help text has also been added to indicate how the default start/end dates are determined and to notify users that the default dates can be modified.

The Enrollment Segment screen has also been enhanced to display the DMIS ID associated with an enrollment segment.

Disenrollment Cancellation/Correction

Prior to CHCS Version 4.6, you could not access a historical enrollment record (MCP Status of Disenrolled) to cancel or correct a disenrollment date. The correction of data associated with a historical enrollment record could only be corrected manually in both the CHCS and DEERS systems.

A new option, Disenrollment Cancellation/Correction (DCAN), on the Enrollment Processing Menu allows users holding the new CPZ DISENROLL CANCEL-CORRECT security key to access the historical enrollment record to cancel or correct a patient's most recent enrollment end date. This option also transmits appropriate transactions to DEERS for sites operating in DEERS Enrollment mode. The MCP status is updated based on the DEERS response to these transaction messages.

The DCAN option is only available if the last enrollment record has the MCP status of Disenrolled.

Disenrollment Grace Period for Active-Duty Beneficiaries (ACV = A)

Prior to CHCS Version 4.6, the enrollments of active-duty beneficiaries expired after the enrollment end date. Beginning with CHCS Version 4.6, a site-definable disenrollment grace period has been added for beneficiaries with an ACV of A (Active Duty).

The system transmits a DEERS eligibility check seven days prior to the grace period expiration date and again on the grace period expiration date. When the DEERS eligibility response is received, the system then updates the MCP end enroll date with the DEERS eligibility end date.

If the enrollment has expired after the grace period, the system updates MCP status from Enrolled to Disenrolled, enters a disenrollment reason, and sends a disenrollment transaction to DEERS. Grace period beneficiaries are not disenrolled until an ineligible response to the DEERS eligibility check submitted on the last day of the grace period has been received from DEERS. Beneficiaries with expired enrollment end dates within the grace period maintain the MCP status of Enrolled.

Also prior to CHCS Version 4.6, the system searched by enrollment end date to determine if a beneficiary should be included in enrollment-related reports. In CHCS Version 4.6, the system looks at the ACV to determine the grace period. If a beneficiary has an ACV value of "A," the grace period is determined by the site-definable grace period parameter setting. The default for this setting is 120 days. MCP users with the CPZ PARAMETERS security key can edit this setting to equal any number between 7 and 120 days. (Menu Path: PAS System Menu → M → FMCP → FTAB → PARA → Active Duty Disenrollment field).

Beneficiaries with expired end dates within the grace period are included as Enrolled in the following MCP reports (refer to List of Sample Reports):

AD Family Members by Unit Enrollment Roster
Menu: PAS System Menu → M → EMCP → OENR → ERPM → ROST → 1

Alphabetic Enrollment Roster by Service
Menu: PAS System Menu → M → EMCP → OENR → ERPM → ROST → 2

Change in Eligibility Enrollment Roster
Menu: PAS System Menu → M → EMCP → OENR → ERPM → ROST → 4

Disenrollees for Period by Reason Code
Menu: PAS System Menu → M → EMCP → OENR → ERPM → ROST → 5

Disenrollment Summary by Reason
Menu: PAS System Menu → M → EMCP → OENR → ERPM → SUMM → 1

Enrollment Summary Report
Menu: PAS System Menu → M → EMCP → OENR → ERPM → SUMM → 2

Patient Category Enrollment Summary
Menu: PAS System Menu → M → EMCP → OENR → ERPM → SUMM → 4

Beneficiaries with enrollment end dates within the grace period are included in the build utility listed below:

Family Batch Enrollment Labels Build Utility
Menu: PAS Syste, Menu → M → EMCP → OENR → ERPM → LABL → 1

The DEERS eligibility check does not update the enrollment end date for Regions 13 and 14.

This functionality is applicable in both Local Empanelment and DEERS Enrollment modes.

Enrolling Division Based on PCM Location

When entering a new enrollment, you are prompted to enter the enrollment start/end dates and to assign a PCM. The system no longer prompts you to enter the enrolling division. The enrolling division is automatically set, based on the place of care division for the selected PCM.

This enhancement is included in all enrollment and batch enrollment processing (Batch PCM Reassignment and Batch AD Enrollment) functions as follows:

– Enrollment Enter/Edit

  The input template displayed in this option continues to display the enrolling division; however, data in this field is “display only” after the PCM is assigned. For a new enrollee, the initial enrollment screen does not display the enrolling division. For an existing enrollee, the enrollment screen displays the place of care division for the enrollee’s assigned PCM.

  When assigning a PCM to a new enrollee, if the selected PCM has multiple places of care for a particular agreement type, the system offers a function key (F9) to view each place of care. The PCM Direct Assignment screen now includes the medical center division associated with the place of care. The PCM Direct Assignment screen also displays the complete ZIP code; prior to the enrollment-based capitation (EBC) special release, the ZIP code was truncated.

– Disenrollment Cancellation

– Active Duty Auto Enrollment

– Batch PCM Reassignment

– Batch Active Duty Enrollment

Prior to the EBC special release, all of the following options allowed you to select the enrolling division or to automatically set the enrolling division based on your default

division. These options have been modified to remove the Enrolling Division prompt; they now set enrolling division based on the place of care for the PCM.

- Mini Registration (Auto Enrollment)
- Disenrollment Cancel (DCAN)
- Batch Renewal (BMER)
- Batch Enroll AD (UBER)

  Previously, this option allowed you to define the default division for enrollment processing. The option has been modified to remove the Enrolling Division prompt. The enrolling division is now set based on the place of care for the PCM.

- Enrollee DMIS ID Update (DMIS)
- Clean Up DMIS ID Update (CLUP)

The Batch PCM Reassignment (BPCM) and the Family PCM Reassign options still allow you to reassign an enrollee to the same PCM but with a different place of care.

Enrollment Cancellation Revisions

The Enrollment Enter/Edit (EENR) and Disenrollment Enter/Edit (DENR) options are no longer used to cancel enrollments. Enrollments can no longer be batch cancelled.

A new option, Enrollment Cancellation (ECAN), replaces prior enrollment cancellation capabilities. This new option automatically sets the disenrollment reason to "Enrollment Cancelled" and updates the enrollment end date to equal the enrollment start date.

The ECAN option allows users to cancel enrollments with the following enrollment statuses:

- A confirmed DEERS enrollment for a future date (Pending Enrollment)
- A confirmed current DEERS enrollment (Enrolled)
- A confirmed DEERS enrollment with an invalid disenrollment transaction (Invalid Disenrollment)
- An enrollment that was rejected by DEERS (Invalid Enrollment).

A DEERS enrollment cancellation message is sent to DEERS if the site is operating in DEERS Enrollment mode, unless the enrollment status is "Invalid Enrollment."

The ECAN option supports enrollment cancellation for individual patients only. Enrollment cancellations cannot be processed for an entire family, and enrollment cancellations cannot be batched.

Enrollment cancellation can only be processed by users holding the CPZ CCP security key and with access to the CHCS enrolling division associated with the enrollment.

Enrollment Reports Modified

The following two reports have been modified to count and report only those records which have the current enrollment statuses of Conditional Enrollment, Pending Enrolled, Enrolled, or Invalid Disenrolled:

- Patient Category Enrollment Summary
- Enrollment Roster for Active Duty Family Members by Unit.

Previously, because an eligibility request is initiated prior to enrollment processing, the input screens did not display the ACV following a confirmed enrollment transaction. To avoid having to process an additional eligibility check to update the ACV and DMIS ID in the Patient file after each enrollment transaction, the system now uses a successful enrollment or disenrollment response to update the ACV and DMIS ID.

Enrollment Reports, New

The DEERS Enrollment Synchronization Report is a new report that counts those enrollees currently assigned the MCP status of Enrolled (with future enrollment end date) or Invalid Disenrollment. The data is sorted by the Enrolling DMIS ID and by ACV within each DMIS ID. This spooled document runs automatically on the first of every month to ensure that the enrollment counts (for enrollments transmitted to DEERS) are generated on the same date as the generation of the DEERS American Standard Code for Information Interchange (ASCII) file. The logic used to generate this report matches the logic used to generate the DEERS ASCII file.

A mail bulletin is transmitted to the CPZ MGR mail group to indicate the spool report is available to be printed through the Print Spool File option on the secondary menu. The DEERS/Enrollment Maintenance Reports Menu (DRPM) also has a new option which allows you to generate this report mid-month (Menu Path: PAS System Menu → M → EMCP → OENR → DRPM→ 5).

For sites in DEERS Enrollment mode, current enrollees with the following ACVs are assumed to have been transmitted to DEERS and are counted in this report:

MCP Patient Type	**ACV**
Active Duty	A TRICARE PRIME (ACTIVE DUTY)
CHAMPUS Eligible	E TRICARE PRIME (CHAMPUS)
Medicare	D MEDICARE DEMONSTRATION

For sites in Local Empanelment mode, the following current enrollees are counted in this report:

MCP Patient Type	ACV
Active Duty	A TRICARE PRIME (ACTIVE DUTY)
Medicare	D MEDICARE DEMONSTRATION

Generate the Enrollment/Disenrollment Discrepancy Report on Demand

Prior to CHCS Version 4.6, you could generate the Enrollment/Disenrollment Discrepancy Report listing invalid enrollment/disenrollment responses from DEERS reported on the previous day. If the report was not printed within the purge parameter (usually every two or three days), the invalid responses from DEERS were deleted and all record of the errors was lost. Also, no secondary sorts were available to the user when printing the Enrollment/Disenrollment Discrepancy Report.

In CHCS Version 4.6, you can generate the Enrollment/Disenrollment Discrepancy Report on request by entering a date range for enrollment start dates, by entering a date range for enrollment transaction dates, or by selecting all existing discrepancies. The primary sort for the report is by enrolling division name. You can also sort by ACV, MCP status, discrepancy code, alpha order, unit, and beneficiary category. The report includes totals of discrepancies for both MCP status and ACV for all the enrollments within a division, the date the enrollment was entered, and the last date the record was modified.

Mini Registration

Each beneficiary registered in CHCS must have a DEERS check performed to determine eligibility for health care. During this transaction, the beneficiary's alternate care plan data is stored in the patient's Patient file, including the ACV, DMIS ID, region code, PCM phone number, and PCM location description.

In CHCS Version 4.6, in PAS specialty and primary care clinics, the system displays the PCM phone number, PCM location description, and the last eligibility check from DEERS for patients remotely enrolled in TRICARE Prime or another benefit. In CHCS V4.5, the system displayed this information for only those patients enrolled locally and did not display the date of the last DEERS check.

In addition, the Enrollment/Empanelment Information screen following Full Registration or Mini Registration has been modified to include the Region Code field and additional DEERS information. These fields are now populated with data downloaded from DEERS and stored in the Patient file if the patient is not enrolled in the local CHCS system and has an ACV other than CHAMPUS Eligible (C) or Direct Care Only (N).This screen now automatically displays for all enrollees, instead of just for local enrollees. For those patients who have an ACV value of C or N (non-enrollees), the system displays a prompt after Mini Registration, asking if you wish to view the Enrollment/Empanelment Information screen.

Update ACV Descriptions

Refer to Table 1-1. Updated ACV Descriptions.

Table 1-1. Updated ACV Descriptions

Code	Old Description	New Description
A	ACTIVE DUTY/MCP ENROLLED	TRICARE PRIME (ACTIVE DUTY)
B	CHAMPVA ELIGIBLE	CHAMPVA (OCONUS)
C	CHAMPUS/DIRECT CARE ELIG	CHAMPUS
D	MCP ENROLLED/CHAMPUS INELIG	MEDICARE DEMONSTRATION
E	MCP ENROLLED/DIR CARE CHAMPUS ELIG	TRICARE PRIME (CHAMPUS)
K	LUKE AFB/WILLIAMS AFB CAM	CATCHMEN AREA MGT
N	NOT ENROLLED/CHAMPUS INELIG	DIRECT CARE ONLY
S *		CHCBP - CONT HLTH CARE BEN PROG
U	ENROLLED IN USTF MANAGED CARE	USTF - UNIF SERV TREAT FACIL
V *		CHAMPVA (CONUS)

* These two codes have been added to the standard ACV file. These codes are not used within CHCS enrollment functionality because they represent other non-TRICARE-related programs. You may see these codes, however, when processing an eligibility request.

Refer to Table 1-2. Inactivated ACVs, for ACVs that no longer valid plan types within DEERS and that have been permanently inactivated from the standard ACV file.

Table 1-2. Inactivated ACVs

Code	Description
F	NON CHAMPUS
G	FORT SIL CAM
H	FORT CARSON CAM
I	CHARLESTON NAVAL HOSP MCP
J	BERGSTROM AFB CAM
L	PREFERRED/ACTIVE DUTY
M	OTHER AND CHAMPVA
O	ENROLLMENT INELIGIBLE
P	ENROLLED IN CHAMPUS PRIME
W	USTF MANAGED CARE 2

Inactivation of these entries prevents the display or use of these codes for future enrollments; however, historical enrollment records may continue to display them.

Update MCP Status Based Upon Successful DEERS Enrollment Response

The system also allows you to retransmit the enrollment-related transactions to DEERS, real time, through a new action bar located in the enrollment process. The individual patient retransmission functionality is available for the MCP status of Enrolled, Invalid Enrolled, Disenrolled, and Invalid Disenrolled. The retransmission may update the MCP status and updates the discrepancy reason associated with the retransmission.

All new enrollments are set to the MCP status of Pending Enrollment, which is automatically updated to either Invalid Enrollment or Enrolled, based on the DEERS eligibility response. Similarly, the MCP status for a disenrollment is set to Invalid Disenrollment until processed by DEERS. Once validated by DEERS, the MCP status is updated accordingly.

- **File and Table Building and Maintenance and Provider Network Management**

Assigning Active Duty to External Network PCMs

The CHCS Version 4.5 software allowed assignment of active-duty beneficiaries to direct-care PCMs with the agreement types of MTF (MTF staff) and CON (Contract).

In CHCS Version 4.6, active-duty beneficiaries may also be assigned network PCMs with the agreement types of SUP (Supplemental Care) and NET (Civilian Network Provider). This applies to PCM batch assignment as well as interactive PCM assignment functions.

The addition of this functionality increases the number of available PCM selections when assigning PCMs to active-duty beneficiaries.

Provider Place of Care Inactivation

In CHCS Version 4.5, authorized MCP users were allowed only to enter a provider or clinic/place of care inactivation date in the future. Then the system checked for pending appointments, wait list requests, and PCM assignments linked to that clinic/place of care. If any discrepancies were found, the system prompted the user to generate a Discrepancy Avoidance Report. Inactivation could not occur until all discrepancies linked to that provider or clinic/place of care were resolved.

In CHCS Version 4.6, authorized MCP users can enter provider or clinic/place of care inactivation dates in the past, present, or future. Provider or clinic/place of care inactivations are now effective on the inactivation date whether or not discrepancies are resolved. A mail bulletin is generated to the appropriate MCP mail group (i.e., CPZMGR), notifying the members of any discrepancies linked to the inactivation. The members of the appropriate mail group are responsible for resolving those discrepancies; i.e., reschedule pending appointments linked to an inactivated provider, modify wait list requests, and reassign patients to a different PCM.

Setting PCM Capacity

The system allows users to set capacity limits on the number of Medicare beneficiaries who may be assigned to individual provider PCMs and provider group PCMs.

In CHCS Version 4.5, PCM assignment capacity limits could be defined for five beneficiary categories (Active Duty, Active Duty Family Member, Retiree, Retiree Family Member, and Other).

In CHCS Version 4.6, a sixth beneficiary category, Medicare, has been added. This category includes patients who are Medicare eligible, are over the age of 65, and are not CHAMPUS eligible. To accommodate the additional beneficiary category, changes were made to data entry, processing, and output of PCM enrollment mix information.

This CHCS Version 4.6 change requires that agreements to define Medicare capacity be established between the MTF and providers before enrolling Medicare beneficiaries.

Since the system categorizes patients who are Medicare eligible according to their DEERS Medicare status, the value of this field must be current for the beneficiary to be correctly categorized.

No changes in security requirements are required for users who are currently authorized to perform PCM assignment or provider network maintenance.

MCP clerks and/or supervisors who currently assign enrollees to PCMs will continue to use the existing enrollment functional pathways.

MCP users who are responsible for maintaining provider network data will continue to access the appropriate enrollment mix screens through the Group Profile/Agreements Enter/Edit (GNET) option or the Individual Provider Profile/Agreements Enter/Edit (INET) option on the Provider Network Management Menu. These users will primarily notice changes in two areas: provider network maintenance and enrolling beneficiaries into the TRICARE Senior option.

No additional security keys have been added for enrollment and provider maintenance beyond those which existed in CHCS Version 4.5

The following reports have been modified to add the Medicare beneficiary category:

– PCM Enrollment Mix Discrepancy Statistical Summary

– PCM Enrollment Mix Discrepancy Report

– Enrollment Roster by PCM

– Available PCM Capacity Report

– Provider Group Report.

- **Managed Care Support Contractor (MCSC) Interface**

MCSC System is a unidirectional interface between CHCS and regional MCSC sites throughout the DOD medical community. The MCSC system is managed by TRICARE through MCP. MCP is a network of contracted healthcare providers who deliver discounted health care services to military beneficiaries for direct care, CHAMPUS, or Medicare. Refer to Addendum 1 – Managed Care Support Contractor (MCSC) Interface.

- **Managing MCP Patient Appointments**

Provider Picklist for “Referred By” Field

In CHCS Version 4.5, when an enrolled or empaneled patient was assigned a PCM that was either a group or a member of a group, the initial provider help/picklist in the "Referred By" field on the Interview/Referral screen in the Health Care Finder Appointment Referral Booking (AHCF) option displayed a help/picklist of all PCMs in the provider network. Consequently, users were unable to single out the members of the group from the master list.

In CHCS Version 4.6, the provider help/picklist for the "Referred By" field on the Interview/Referral screen in the AHCF option has been modified to initially display alphabetically only those providers who are members of the group when the enrollee's/empanelee's PCM is a group, regardless whether an individual provider is a PCM. The provider's status of active or inactive from the MCP Provider file also displays on the help list. An alphabetical list of all providers is displayed if the user needs additional help.

If the patient is not enrolled in MCP, the initial provider help/picklist displays all the network providers in alphabetical order.

- **Medicare Demonstration Project**

The Medicare Demonstration Project is a pilot program implemented at six selected CHCS Version 4.5 sites. This project identifies patients in CHCS who are eligible for Medicare benefits (i.e., ACV of D), and who are enrolled into the TRICARE Senior option program at the selected sites. Once Medicare enrollees have been identified at these sites, CHCS will transmit their enrollment data to DEERS. Refer to Appendix C Medicare Demonstration.

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Section 2 File and Table Building and Maintenance/Provider Network Functions

2. FILE AND TABLE BUILDING AND MAINTENANCE/PROVIDER NETWORK FUNCTIONS

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Introduction

Before enrollment and booking take place using the Managed Care Program (MCP) module of the Composite Health Care System (CHCS), the files and tables must be completed and several files linked together using the Group Profile/Agreements Enter/Edit (GNET) option.

Some files come populated, requiring minimal or no data entry. Others may not require entry if the Medical Treatment Facility (MTF) does not plan to use these resources.

Refer to Table 2-1. Creating Primary Care Managers (PCMs), page 2-4, for a quick reference to the step-by-step procedure.

Table 2-1. Creating Primary Care Managers (PCMs)

Issues to consider before associating the places of care and providers with provider groups.

1. Will the group be a PCM?
2. Will the providers be PCMs as well?
3. Will the group have only one place of care (clinic) or will it have multiple places of care?
4. If the group is a PCM and the providers are not, ALL provider schedules display.
5. If the group is a PCM and some but not all providers are PCMs, only schedules for providers designated as PCMs display.
6. If the group is not a PCM and some providers are PCMs with assigned enrollees, only the individual PCM schedules display.
7. If MCP groups are PCMs, the UIC/PCM link must be established with the group after it has been designated a PCM if the group treats active-duty personnel.

Designate a provider group as a PCM

1. Access the Group Profile/Agreements Enter/Edit (GNET) option on the Provider Network Management Menu.
2. Enter the Provider Group name at the *Select Provider Group* prompt.
3. Enter “YES” at the *Activate Group Provider* field and press <Next Screen>.
4. Press <Return> to accept the default (A)greements action.
5. Enter “M” to choose the Enrollment (M)ix action.
6. Select the Agreement Type(s) and press <Return>.
7. For each Agreement Type selected, enter “YES” at the *Activate Group PCM* field on the Provider Group PCM Capacity screen and press <Next Screen> twice.
8. File the data.

Designate an individual provider as a PCM

1. Access the Group Profile/Agreements Enter/Edit (GNET) option on the Provider Network Management Menu.
2. Enter the Provider Group name at the *Select Provider Group* prompt.
3. Press <Next Screen> to access the Provider Group Profile/Agreement Maintenance action bar.
4. Enter “P” to choose the (P)roviders action.
5. Enter “X” to choose the Agreement e(X)ceptions action.
6. Select the provider(s) to designate as PCM(s).

For each provider selected:

1. Enter “M” to choose the Enrollment (M)ix action.
2. Select the Agreement Type(s) and press <Return>.

For each Agreement Type selected for that provider:

1. Enter “YES” at the *PCM* field.
2. Press <Next Screen> twice and file the data.

File building sequence at new MCP sites is as follows:

1. Facility File/Table Maintenance (FTAB)

Several files require input. Others require no or minimal entry.

2. Enrollment File/Table Maintenance (ETAB)

Files are already populated so that no or minimal new data is required. All files here should be reviewed for Medical Treatment Facility (MTF) customization.

3. Provider Network File/Table Maintenance (PTAB)

Several files require entries or require that a user press <Return> to advance through all fields. Others require little or no data entry but should be reviewed for accuracy.

4. Group Profile/Agreements Enter/Edit (GNET)

Files established or reviewed in the FTAB, ETAB, and PTAB options are linked in this option to complete the file/table build.

5. TaskMan Options

The system specialist or data base administrator (DBA) must schedule several TaskMan options for the MCP module to function as designed.

6. MCP Mail Bulletins

The DBA must establish mail groups and task mail bulletins to alert MCP users of activities and changes to the MCP files.

7. All Other MCP Files

These files are populated as entries are made using the MCP software during normal operation.

- **Business Rules**

– MTF clinics and providers must be accessed through MCP. Press <Return> to advance through all fields to establish them in the MCP software. Do not use <Do>, <Next>, or <F10> during this process. This ensures that all pointers in the software are established in MCP.

– Determine if the enrollment mode will be full Defense Enrollment Eligibility Reporting System (DEERS) enrollment or Local Empanelment mode. The DEERS enrollment mode sends a transaction for all enrollment transactions on all patients in the MCP Patient file. Local Empanelment mode sends transactions only for active-duty beneficiaries.

– Contact the lead agent in your region to verify the enrollment mode to use.

– Establish who the PCMs are and whether enrollments/empanelments will be to a group (team) or to individual providers.

– If enrolled to a group (team), providers may be added or deleted from the group without having to reassign beneficiaries. Enrollment/empanelments to an individual provider require reassignment of patients when the provider moves.

– If the group is a PCM:

- Schedules display for all providers in the place of care where the patient is enrolled.
- When assigned a PCM, patient is linked to the provider, an individual place of care, and a provider specialty.

2.1 File And Table For MCP Menu (FMCP)

Menu Path: PAS System Menu → M → FMCP

```
   ETAB   Enrollment File/Table Maintenance Menu
   FTAB   Facility File/Table Maintenance Menu
   PTAB   Provider Network File/Table Maintenance Menu

Select File/Table for MCP Menu Option:
```

Figure 2-1. File/Table for MCP Menu

2.1.1 Enrollment File/Table Maintenance Menu (ETAB)

Menu Path: PAS System Menu → M → FMCP → ETAB

Introduction

Site-definable parameters are not established through these menus. MTFs upgrading from CHCS Version 4.41 to CHCS Version 4.51 must use the Enrollee DMIS ID Update (DMIS) option to send the enrolling division of all enrolled patients to DEERS. DMIS ID stands for Defense Medical Information System identification. Refer to Section 2.1.1.10 Enrollee DMIS ID Update (DMIS), page 2-44).

No special file build sequence is necessary in these menus. Most files are already populated and may only require minimal or no additional build.

```
   INSU   Insurance Company Enter/Edit
   PCMA   PCM Assignment Reason Enter/Edit
   DISE   Disenrollment Reason Enter/Edit
   FORM   MCP Forms Text Enter/Edit
   EMBA   MCP Embosser Attribute Enter/Edit
   EMBC   MCP Embosser Cards Enter/Edit
   EMBT   MCP Embosser Type Enter/Edit
   EBRE   Enrollment Block Reason Enter/Edit
   LORE   Enrollee Lockout Override Reason Enter/Edit
   DMIS   Enrollee DMIS ID Update
   CLUP   Clean Up DMIS ID Update

Select Enrollment File/Table Maintenance Menu Option:
```

Figure 2-2. Enrollment File/Table Maintenance Menu

2.1.1.1 Insurance Company Enter/edit (INSU)

Menu Path: PAS System Menu → M → FMCP → ETAB → INSU

- **Security Keys**

CPZ CCP
CPZ FILE
FileMan Code "A"

- **Required Fields**

Insurance Company Name
Insurance Co File

- **Application Description**

This option allows you to enter new insurance companies into CHCS. This file is built primarily by the Patient Administration (PAD) Subsystem users when recording registration information. This insurance file is also referenced during enrollment processing.

- **Business Rules**

– Before MCP enters a new insurance company, ensure PAD is aware and compliant.
– Enter data strictly along PAD guidelines.
– Never make duplicate entries in this file.
– Do not delete entries. DO NOT PRACTICE in this file.
– If unsure of the data to enter or if the data is unknown, DO NOT enter anything and refer this to PAD personnel.

- **Other Important Considerations**

The MTF must decide whether PAD will allow TRICARE to make entries into this file. This is a PAD file for third-party collections (TPC).

- **Data Entry Process**

Enter a new insurance company

Access the INSU option

Enter name of new insurance company

Enter a short unique name for this new company

Complete the Insurance Company – Enter/Edit screen

File the data

Enter another insurance company or exit the option

Access the INSU option

Enter name of new insurance company

Enter the name of the new insurance company and press <Return>. If this is a new insurance company, the system asks you to verify that it is new.

Enter a short unique name for this new company

This name should be an abbreviated name of the insurance company, 3-14 characters long, and must be unique. This short name may be used to look up insurance companies and displays on TPC reports.

After you enter the short insurance company file name, the Insurance Company - Enter/Edit screen displays. Refer to

Figure 2-3. Insurance Company Enter/Edit Screen, page 2-11.

Complete the Insurance Company – Enter/Edit screen

```
INSURANCE CO FILE: INSURA                  INSURANCE COMPANY - ENTER/EDIT

      Insurance Company Name: AAA INSURANCE CO.
                   Qualifier:
  Short Name (Standard Code): INSURA                      Attorney?
            TPOCS Print Type:                 Unknown Ins Company?

   Blue Cross/Blue Shield Code:             Date Last Updated: 20 Jun 2001
Electronic Data Interface Code: 13579           Inactive Date: 24 Jun 2001

 Claims Address: 329 MORRISEY DRIVE
           City: SAN DIEGO                 State: CALIFORNIA  Zip: 92123

 Claims Contact Person: Ms. Helen Craig
        Phone Number 1: (619) 555-2332        ext: 143
        Phone Number 2:                       ext:
            FAX Number: (619) 555-7155

      Standard Comment:

    Local Comment:
```

Figure 2-3. Insurance Company Enter/Edit Screen

1. Insurance Company Name

Required field that defaults to the name entered initially (e.g., AAA Insurance Co).

2. Qualifier

Optional field that may be used to provide additional company information, such as a region, distinguishing it from other companies with the same name.

3. Short Name (Standard Code)

Required field that should default from the initial screen entry. This is a unique identifier for this company and may also be used as a quick lookup code.

4. Attorney?

Optional field that may be left blank. Should be set to YES if this entry is a law firm or attorney intended for use by PAD on copying charge receipts.

5. TPOCS Print Type

Optional field that is intended as a code to identify the type of claim form used for billing by the Third Party Outpatient Collection System (TPOCS). DO NOT ENTER DATA in this field and forward to PAD for completion.

6. Unknown Ins Company?

Should be set to YES if this company is to be used as placeholder for patients whose insurance carrier is not

known. Only a single entry in the insurance table should be identified and used for this purpose.

This field enables sites to track those policies which require followup before they can be billed. Patient policies assigned the UNKNOWN company will be listed on the Report of Policies with Unknown Companies for resolution.

7. Blue Cross/Blue Shield Code

Optional, free-text field for a code used by some Blue Cross/Blue Shield plans. Bypass this field if the code is unknown by pressing <Return>.

8. Date Last Updated

System default; no data entry is required or allowed.

9. Electronic Data Interface Code

Optional field that identifies this insurance company if claims are billed electronically. Bypass this field if unknown.

10. Inactive Date

The date a company is considered inactive in CHCS. Optional field that may be bypassed by pressing <Return>.

11. Claims Address

The address for submitting claims. This field may be bypassed by pressing <Return> if the address is unknown.

12. ZIP

The cursor advances to this field and enters the City and State fields from the ZIP code entry.

13. Claims Contact Person

The person at the insurance company who serves as the primary contact for your MTF.

14. Phone Number 1, Phone Number 2, and Fax Number

The numbers for this insurance company. Should be entered Area Code-Prefix-Line Number. The fields should contain the direct extension number of the primary contact.

15. Standard Comment

Bypassed; no data entry allowed.

16. Local Comment

Store any other data you may wish to keep for this insurance company. This is a free-text field of up to 60 characters.

File the data

When you complete data entry, you may file this screen and exit to the *Select Insurance* prompt.

Enter another insurance company or exit the option

Repeat the process for any other insurance company. You may edit an insurance company by accessing it through this menu option. All fields initially accessible are editable.

- **Functionality Interactions**

This is a PAD file. Entries in this file affect PAD, Medical Services Accounting (MSA), and TPC. Be sure to coordinate with PAD prior to making new entries or editing existing ones.
Pharmacy may also obtain information from this file as well as propose new entries for their TPC programs. They should contact PAD and have them provide the information.

- **Troubleshooting**

If you are unable to enter an insurance name while in the functionality, review this file to ensure the entry was made and the company is active.

2.1.1.2 PCM Assignment Reason Enter/Edit (PCMA)

Menu Path: PAS System Menu → M → FMCP → ETAB → PCMA

- **Security Keys**

CPZ CCP
CPZ FILE

- **Required Fields**

PCM Assignment Reason
Description

- **Application Description**

This option is used to enter codes for reasons why a beneficiary may want to change to a different PCM.

- **Business Rules**

– This contains entries that should not be modified.
– Use codes to change a PCM or reassign a beneficiary to a different PCM. Do not use for initial assignment.
– Use this option to add new codes as needed at your MTF.

- **Other Important Considerations**

The MTF may add to the reasons already stored in CHCS.

- **Data Entry Process**

Enter a new PCM assignment reason

Access the PCMA option

Enter the new code

Complete the MCP PCM Assignment Reason Enter/Edit screen

File the code

Enter another code or exit the

Access the PCMA option

Enter the new code

At the *Select PCM ASSIGNMENT REASON* prompt, enter the code to be used for the new reason (e.g., PCS for provider PCSed) and verify that you want to add a new code for this file. Enter a double question mark (??) to display the list of PCM assignments already entered. The system displays the MCP PCM Assignment Reason Enter/Edit screen. Refer to Figure 2-4. MCP PCM Assignment Reason Enter/Edit Screen, page 2-16.

Complete the MCP PCM Assignment Reason Enter/Edit screen

The Code field displays the code you entered in the previous screen.

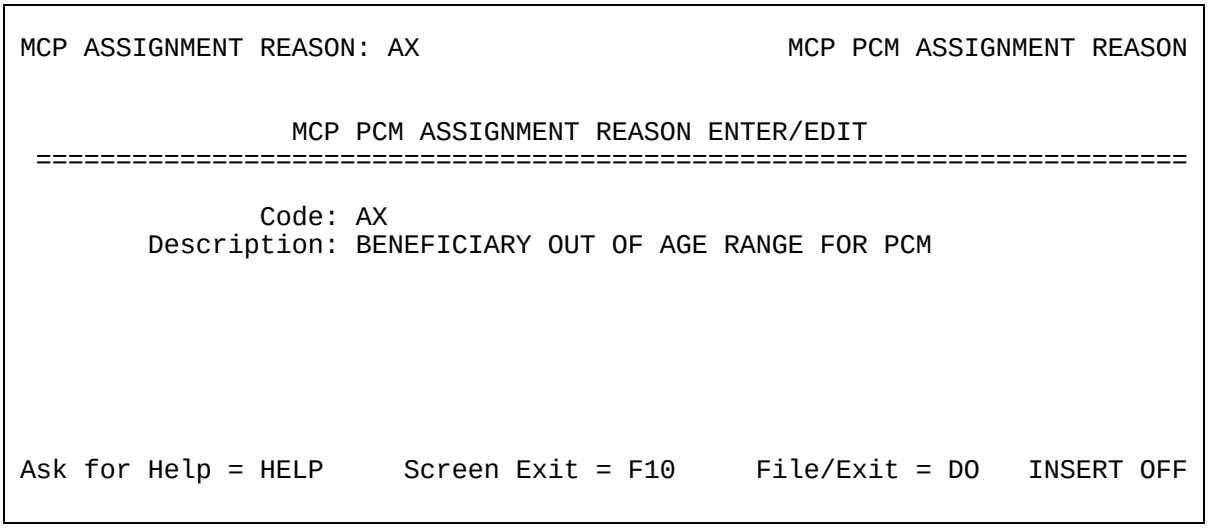


Figure 2-4. MCP PCM Assignment Reason Enter/Edit Screen

1. Code

Edit or press <Return> to verify. To edit the Code field, type in a unique entry of 2 to 4 characters.

2. Description

Description of the code of 3 to 40 characters. This system-required field may be edited any time in this option.

File the code

Enter another code or exit the option

- **Functionality Interaction**

None

- **Troubleshooting**

If the code you desire is not found in CHCS when reassigning a PCM, review this file to determine if the entry is in the file. You can use the PCMA option to enter the code if you have the CPZ CCP and CPZ FILE security keys.

2.1.1.3 Disenrollment Reason Enter/Edit (DISE)

Menu Path: PAS System Menu → M → FMCP → ETAB → DISE

- **Security Keys**

CPZ CCP
CPZ FILE

- **Required Fields**

Disenrollment Reason
Description

- **Application Description**

This option is used to enter new reasons why enrolled beneficiaries may disenroll from TRICARE Prime.

- **Business Rules**

– Do not change existing entries.

- **Other Important Considerations**

The MTF should review the existing file entries and decide whether to use existing entries or create new ones.

- **Data Entry Process**

Enter a new disenrollment reason

Access the DISE option

Enter the new code

Complete the MCP Disenrollment Reason screen

File the data

Enter another disenrollment reason or exit the option

Access the DISE option

Enter the new code

Enter the code for the new reason at the *Select DISENROLLMENT REASON* prompt. Verify that you want to add a new reason.

Complete the MCP Disenrollment Reason screen

```
MCP DISENROLLMENT REASON: DE                    MCP DISENROLLMENT REASON


                     MCP DISENROLLMENT REASON ENTER/EDIT
=============================================================================

               Code: DE
        Description: DISENROLLMENT/EXPIRATION




Ask for Help = HELP     Screen Exit = F10    File/Exit = DO    INSERT OFF
```

Figure 2-5. MCP Disenrollment Reason Screen

1. Code

Displays the code you entered at the *Select DISENROLLMENT REASON* prompt and may be edited.

2. Description

Required field. Enter 3 to 40 characters to describe the code you just entered.

File the data
Enter another disenrollment reason or exit the option

- **Functionality Interactions**

This file does not affect any other functionality.

- **Troubleshooting**

If a reason for disenrollment cannot be found during a disenrollment, review this file to ensure the entry was made.

2.1.1.4 MCP Forms Text Enter/Edit (FORM)

Menu Path: PAS System Menu → M → FMCP → ETAB → FORM

- **Security Keys**

CPZ CCP
CPZ FILE

- **Required Fields**

Type of Form

- **Application Description**

This option contains the text of the following forms: care authorization forms (CAFs) used in the Health Care Finder (HCF) menus; disenrollment and renewal notification letters used in the Multiple Batch Renewal and Disenrollment functions; and enrollment forms printed after a patient is enrolled.

- **Business Rules**

– The format used for these forms appears on either a CAF, notification letter, or an enrollment form whenever any of the forms are generated.

– You must use this option to complete a form before the form may be used.

– The format used for these forms is shared by all divisions; that is, it is not division specific.

– Each MTF may change the wording in each form, but the text may not have more lines than what appears at the top of the form in this option.

– Any of the forms may print on two pages if longer than 20 lines.

- **Other Important Considerations**

The MTF must decide what information to include in each form. Each form should be printed and reviewed for accuracy.

The MTF must be aware that some forms are initially blank and must be edited prior to use.

Since none of the forms is division specific, all MTFs must concur on the text to be used with these forms. The system administrator may create a site-specific security key for this option.

The CAF is the form used by PCMs to authorize the care of TRICARE Prime enrollees by civilian/specialty providers.

- **Data Entry Process**

Edit a form

Access the FORM option

Enter the form to be edited

Edit the text

File the data

Enter another form or exit the

Access the FORM option
Enter the form to be edited

Enter the name of the form you desire at the *Select TYPE OF FORM* prompt. The form must already exist in the Form file. No new entries are allowed.

Edit the text

Edit the form selected on the CP Forms Text screen. Refer to Figure 2-6. CP Forms Text Screen, page 2-22.

```
MCP FORM TEXT: CAF-DIRECT CARE                                  CP FORMS TEXT

   Maximum Text Lines: 7
 This Care Authorization covers necessary specialty care directed by the
 primary care provider and authorized by the Primary Care Manager.  The
 care covered may be provided either within the MTF or by one of the
 civilian network providers.

 As a MCP HMO Option participant, the patient is responsible for cost
 shares accrued during this episode of care.




Ask for Help = HELP     Screen Exit = F10     File/Exit = DO   INSERT OFF
```

Figure 2-6. CP Forms Text Screen

Existing MCP form text entries that may be edited are as follows:

CAF-ACTIVE DUTY
CAF-CHAMPUS ELIGIBLE
CAF-DIRECT CARE
CAF-MCP/ACTIVE DUTY
CAF-MCP CHAMPUS ELIGIBLE
CAF-MEDICARE
CAF-NON-ENROLLED/ACTIVE DUTY
CAF-NON-ENROLLED/CHAMPUS ELIGIBLE
CAF-NON-ENROLLED/DIRECT CARE ONLY
CAF-OTHER
CAF-SUPPLEMENTAL CARE DIAGNOSIS
DISENROLLMENT NOTIFICATION
ENROLLMENT FORM
RENEWAL NOTIFICATION

File the data

Enter another form or exit the option

- **Functionality Interactions**

None

- **Troubleshooting**

If a form is incorrect for your facility, you may edit it through this option.

2.1.1.5 MCP Embosser Attribute Enter/Edit (EMBA)

Menu Path: PAS System Menu → M → FMCP → ETAB → EMBA

- **Security Keys**

CPZ CCP
CPZ FILE

- **Required Fields**

Embosser Type Attributes
Type of Embosser

- **Application Description**

This option allows you to associate software attribute codes that are inherent with different embossers without having to hard code the attributes and codes for each type of embosser. The codes can be literal text strings or an interpreted variable, such as $C(13), that is sent to the embosser.

- **Business Rules**

– Contact the system specialist for assistance.

- **Other Important Considerations**

PAD software uses this file. You should contact PAD personnel as well as the system specialist before making any entries.

- **Data Entry Process**

Enter or edit embosser attributes

Access the EMBA option

Select embosser type attributes

Complete the DG Embosser Attribute Edit screen

File the data

Enter another embosser attribute or exit the option

Access the EMBA option

Select embosser type attributes

Enter a double question mark (??) at the *Select EMBOSSER TYPE ATTRIBUTES* prompt to display a picklist of attributes. Choose the appropriate attribute from this list.

The system displays the DG Embosser Attribute Edit screen. Refer to Figure 2-7. DG Embosser Attribute Edit Screen, page 2-25.

Complete the DG Embosser Attribute Edit screen

```
EMBOSSER TYPE ATTRIBUTES: DOUBLE HEIGHT        DG EMBOSSER ATTRIBUTE EDIT

 ATTRIBUTE: DOUBLE HEIGHT
 STARTING CODE: (
 ENDING CODE: )
 TYPE OF EMBOSSER: DATACARD 310 (OPEN)
 STATUS: ACTIVE









Ask for Help = HELP     Screen Exit = F10     File/Exit = DO   INSERT OFF
```

Figure 2-7. DG Embosser Attribute Edit Screen

1. Attribute

Used to format the card. Enter the special print characteristic used by the embosser type to format the emboss card. This defaults from the initial entry.

2. Starting Code

The starting code associated with the referenced type attribute obtained from the embosser user manual. The code is either an interpreted or literal string.

3. Ending Code

The ending code associated with the referenced type attribute obtained from the embosser user manual. The code is either an interpreted or literal string.

4. Type of Embosser

The embosser type associated with this attribute (e.g., Datacard 310 open). The embosser type should already be listed in the file. Enter a double question mark (??) to display a picklist.

5. Status

Indicates whether this attribute is active.

File the data

Enter another embosser attribute or exit the option

- **Functionality Interactions**

Embossers may also be entered into this file through the PAD software. Coordinate with PAD personnel to avoid conflicts.

PAS may also use this file through the ER menus.

- **Troubleshooting**

If your embosser does not work, contact the systems specialist.

2.1.1.6 MCP Embosser Cards Enter/Edit (EMBC)

Menu Path: PAS System Menu → M → FMCP → ETAB → EMBC

- **Security Keys**

CPZ CCP
CPZ FILE

- **Required Fields**

Embosser Format
Type of Emboss Card
Type of Embosser

- **Application Description**

This option allows you to define the type of embosser cards generated by the subsystem, and the information to be embossed on each card. It allows you to build or modify a print template for the card embosser.
This option allows you to edit the fields to be displayed on an embosser card and to display or print a test card.

- **Other Important Considerations**

PAD and Patient Appointment and Scheduling (PAS) software also allow printing of embosser cards. Do not edit existing entries in this file.

- **Data Entry Process**

Enter/edit/test emboss card format

Access the EMBC option

Select (E)dit or (T)est from the action bar

Enter the embosser format name

Complete the DG Emboss Card Edit Main Screen

Complete the DG Emboss Card Edit - Continuation Screen

File the data

Check for format problems if desired

Display a test card if desired

Print an embossed card if desired and able

Edit/test another format or exit the option

Access the EMBC option

Select (E)dit or (T)est from the action bar

Choose an action from the following action bar:
Select (E)dit Emboss Card Format, (T)est Emboss Card Format, (Q)uit:

Enter the embosser format name

If you select (E), enter the embosser format name and proceed to DG Emboss Card Edit screen. Refer to Figure 2-8. DG Emboss Card Edit Main Screen, page 2-29. If you select (T), bypass steps 4 and 5.

Complete the DG Emboss Card Edit Main Screen

```
EMBOSSER FORMAT: INPATIENT                              DG EMBOSS CARD EDIT

 NAME: INPATIENT

 DIVISION(S):
 DIV A - TRAINING HOSPITAL


 NUMBER OF ROWS IN FORMAT: 9           NUMBER OF EMBOSS CARDS: 1
 TYPE OF EMBOSS CARD: INPATIENT
 TYPE OF EMBOSSER: DATACARD 310 (OPEN)
 TYPE OF PATIENT:
 DEFAULT EMBOSSER DEVICE: 2377
 STATUS: ACTIVE                        SHORT NAME:
 Select PRINT FIELDS:
 ADMISSION DATE
 AGE
 CLINICAL SERVICE
 FMP
 MTF CODE
 NAME
 PATIENT CATEGORY DESCRIPTION
 RANK
 REGISTER NUMBER
 RELIGION
 SEX
 SSN WITH DASHES
 WARD ABBREVIATION
```

Figure 2-8. DG Emboss Card Edit Main Screen

1. Name

The name of the embosser format. Edit or press <Return> to verify the name.

2. Division(s)

The division where this card will be used or blank if it is used for all divisions.

3. Number of rows in format

The number of lines of print each card will use, including blank lines.

4. Number of emboss cards

The number of cards to be printed for each patient.

5. Type of emboss card

Limits the possible selection of print fields which pertain to the emboss card selected. The choices are:

I Inpatient cards.

O Outpatient cards.

U Unspecified. TRICARE membership cards should use this type. This entry limits the possible selections of print fields to just inpatient or outpatient.

6. Type of embosser
The type of embosser used (e.g., Datacard 310). Enter a double question mark (??) to display a picklist of embossers available. If the correct type is not listed, it may be entered into CHCS through the EMBT option (Menu Path: PAS System Menu → M → FMCP → ETAB → EMBT).
7. Type of patient
Type of patient for whom this card is intended or blank if used by both sponsors and family members. The choices are:

D Family member
S Sponsor

8. Default embosser device
Used if this card has a default device. If no default device exists and the field is left blank, you are prompted for a device when printing cards.
9. Status
Indicates whether the referenced embosser card is active.
10. Short name
A short name that identifies this embosser format and can be used as a quick lookup.
11. Select print fields
The print fields that print on this emboss card. The list of selectable print fields varies depending on the type of emboss card specified earlier (Inpatient/Outpatient/Unspecified). Enter a double question mark (??) to display the choices. Each new print field requires completion of several fields on the DG Emboss Card Edit - Continuation Screen.

Complete the DG Emboss Card Edit – Continuation Screen

1. Field
The name of the print field that displays on the emboss card.
2. Row
The row on which the label print field is placed.
3. Column
The column in which the first character of the print field displays.
4. Title

Optional field. Displays in front of the selected print field (e.g., AGE: 16). If no title is entered, the data prints without a title.

5. Literal Text

Free-text field, 1 to 80 characters, for site-definable needs (e.g., PERSONAL DATA/PRIV ACT 1974).

6. Length

Length of the print field specified on the card (e.g., 30).

7. Select Attribute

Optional field. Enter a double question mark (??) to display a picklist. Attributes affect numeric fields such as Social Security number (SSN) and family member prefix (FMP). An example attribute is:

DOUBLE HEIGHT DATACARD 310 (OPEN) ACTIVE

File this screen and repeat the process for each desired print field.

File the data

Check for format problems if desired

Check for card format errors by accepting the default and viewing the card format. You can check the format only once. Use (T)est afterwards.

Display a test card if desired

Display a test emboss card by accepting the default at the next prompt, *Do you wish to check for format problems on the emboss card? YES//* If changes are necessary, you may return to edit.

Print an embossed card if desired and able

Print a card by accepting the following default and entering an embosser at the following prompt.

Edit/test another format or exit the option

Repeat the process by selecting (E)dit or (T)est from the action bar to test the card format on screen. Enter (Q)uit to exit this option.

- **Functionality Interactions**

PAD and PAS users can generate embossed cards and share the format; therefore, any change to these formats may affect other users. Do not change existing entries.

- **Troubleshooting**

If your embosser does not work, contact the systems specialist.

2.1.1.7 MCP Embosser Type Enter/Edit (EMBT)

Menu Path: PAS System Menu → M → FMCP → ETAB → EMBT

- **Security Keys**

CPZ CCP
CPZ FILE

- **Required Fields**

Embosser Type Name
Starting Code Type
Ending Code Type
CRLF Type
MAXCOL
MAXROW

- **Application Description**

The embosser type should be defined by a systems specialist.
This option allows you to define embosser equipment types. This file tells the embosser equipment when to start and end data printing, spacing, indent, and maximum number of columns and rows. This file comes with defaults that may be modified.

- **Business Rules**

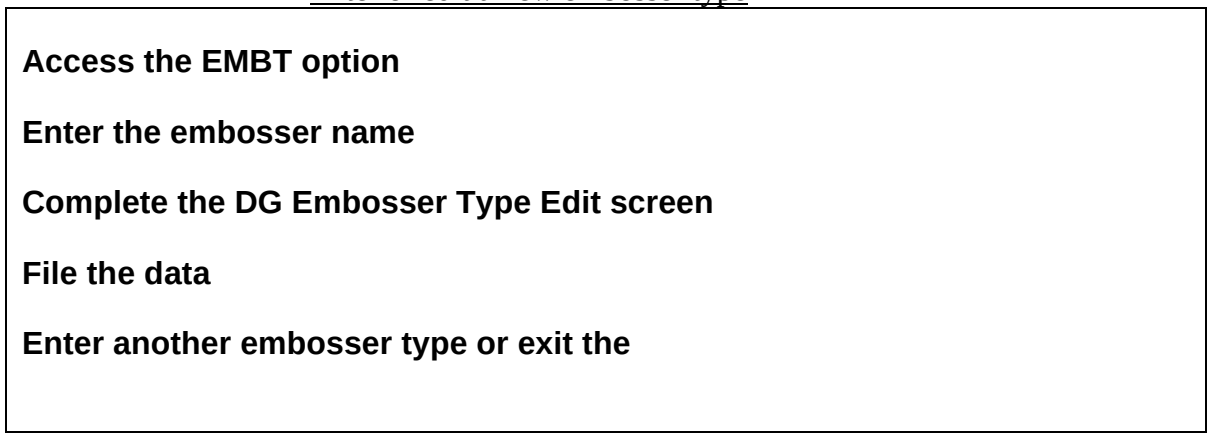
– Ask the system specialist to assist with this file.
– Do not edit or delete existing entries. They may be in use by another functionality.

- **Other Important Considerations**

This is a shared file with PAD and PAS. Do not change existing entries.

- **Data Entry Process**

Enter or edit a new embosser type



Access the EMBT option
Enter the Embosser name
Example: DATACARD 310

Complete the DG Embosser Type Edit screen

```
EMBOSSER TYPE: ADVANTAGE 250 (OPEN)                DG EMBOSSER TYPE EDIT

 NAME: ADVANTAGE 250 (OPEN)
 STARTING CODE: <
 STARTING CODE TYPE: LITERAL
 ENDING CODE: >
 ENDING CODE TYPE: LITERAL
 CRLF: $C(13)                              CRLF TYPE: INTERPRETED
 SPACE:                                    INDENT: 0
 MAXCOL: 32                                MAXROW: 11
 NON PRINTABLE CHARACTERS: ~`!@#$%&*()_+={}[]:;"| ?><



Ask for Help = HELP     Screen Exit = F10     File/Exit = DO   INSERT OFF
```

Figure 2-9. DG Embosser Type Edit Screen

1. Name

The embosser name. Edit or press <Return> to verify the name.

2. Starting Code

Code that tells the embosser that the following data is to be printed on the emboss card. This can be an actual character that the embosser recognizes or Massachusetts General Hospital Utility Multi-Programming System (MUMPS) programming variable that must be interpreted. The code is 1 to 60 characters and is determined by the embosser equipment and format used (e.g., <).

3. Starting Code Type

Code that tells the embosser whether the starting code is literal text (text written to the embosser) or interpreted (text that must be interpreted as a MUMPS variable). Choices are:

I	Interpreted
L	Literal

4. Ending Code
Code that tells the embosser that no more data is to be printed on the emboss card. This can be an actual character that the embosser recognizes or a MUMPS programming variable that must be interpreted.
5. Ending Code Type
Code that tells the embosser whether the ending code is literal text (text written to the embosser) or interpreted text that must be interpreted as a MUMPS variable. Choices are:

I Interpreted
L Literal

6. CRLF
Code that tells the embosser that the end of the line has been reached. It forces a carriage return (CR)/line feed (LF). The code can be characters recognized by the embosser or a MUMPS code that must be interpreted.
7. CRLF Type
Code that tells the embosser whether the CRLF type is literal text written to the embosser or interpreted text that must be interpreted as a MUMPS variable. Choices are:

I Interpreted
L Literal

8. Space
Literal characters that tell the embosser to print a space. These must be actual characters that the embosser recognizes; they cannot be a MUMPS variable that must be interpreted. This field is 1 to 30 characters. The code depends on the embosser model (e.g., {).
9. Indent
The number of columns that the emboss card should be indented before it prints the first character. If no entry is made, the system enters a zero (0). You should enter at least 2, to keep the printed characters off the edge of the card.
10. MAXCOL
The maximum number of characters that the emboss card can have on a given line. This includes the indented characters, headers, fields, and literal text. This can also serve as a left margin. This setting depends on the size of the card. If a card can accomodate 32 characters per line at 10 characters per inch (the basic card format) you should

make the MAXCOL 30 characters, allowing two to keep the text off the edge of the card (e.g., 30).
11. MAXROW
The maximum number of rows for the emboss card, normally 9 to 11 lines. The printed format always starts at the top of the card. Any number less than the maximum removes lines from the bottom of the card.
12. Non printable characters
The characters that the embosser uses to control printing. The characters entered in this field do not print on the card. A caret (^) cannot be entered in this field; it is not a printable character. All lowercase characters are translated to uppercase and, therefore, need not be added to this field. Examples: !@#$%&*()_+={}[]:"|;'.?<>.

File the data
Enter another embosser type or exit the option.

- **Functionality Interactions**

PAD and PAS can also print embosser cards and share the formats. Do not change existing entries.

- **Troubleshooting**

If your embosser does not work, contact the systems specialist.

2.1.1.8 Enrollment Block Reason Enter/Edit (EBRE)

Menu Path: PAS System Menu → M → FMCP → ETAB → EBRE

- **Security Keys**

CPZ CCP
CPZ FILE
CPZ Batch Enroll – For users performing batch enroll.
CPZ Identify AD – For users performing batch enroll.

- **Required Fields**

MCP Enrollment Block Reason
Description

- **Application Description**

This option allows you to enter a new enrollment block reason code and description for use with the Batch Active Duty Enrollment option on the Enrollments Menu.

- **Business Rules**

– Do not modify existing entries.
– The MTF should review this file and enter new reasons for use with the batch enrollments function.
– While performing the batch enroll function, CHCS checks each potential candidate's record for these block

codes. If any exist in the patient record, no enrollment takes place.

- **Other Important Considerations**

Since the AD Batch Enrollment option is performed for all divisions, the MTF policy should clearly define the use of each block code.

- **Data Entry Process**

Enter a new enrollment block reason code

Access the EBRE option

Enter the new enrollment block reason code

Complete the MCP Enroll Block Reason screen

File the code

Enter another code or exit the option

Access the ERBE option

Enter the new enrollment block reason code

At the *Select ENROLLMENT BLOCK REASON* prompt, enter the new 3 to 4 character code you desire or the code to edit. Enter a double question mark (??) to display codes already entered:

DIS	ALREADY DISENROLLED
ENT	ENTITLEMENT DISCREPANCY
OTH	OTHER
REN	ALREADY RENEWED

The following nine additional codes are used by the system only and can only be seen through FileMan:

AGR	PCM AGREEMENT NOT ACTIVE
CAP	INSUFFICIENT CAPACITY FOR PCM
DEER	NO DEERS ELIGIBILITY RESPONSE RECEIVED
ENR	ALREADY ENROLLED
INEL	PATIENT INELIGIBLE ON DEERS
PCAT	PATIENT CATEGORY CODE HAS CHANGED
PCM	NO DEFAULT PCM FOR THE UIC
PCS	CANDIDATE HAS LEFT THE AREA
UIC	NOT A VALID UIC

After you enter one of the four codes available to you or enter a new code, the system displays the MCP Enroll Block Reason screen. Refer to Figure 2-10. MCP Enroll Block Reason Screen, page 2-40.

Complete the MCP Enroll Block Reason screen

The Code field displays the code you entered at the *Select ENROLLMENT BLOCK REASON* prompt. The cursor is at the Description field.

```
MCP ENROLLMENT BLOCK REASONS: DIS                    MCP ENROLL BLOCK REASON


                  MCP ENROLLMENT BLOCK REASON ENTER/EDIT
 ======================================================================

               Code: DIS
        Description: ALREADY DISENROLLED




Ask for Help = HELP     Screen Exit = F10     File/Exit = DO   INSERT OFF
```

Figure 2-10. MCP Enroll Block Reason Screen

1. Code

To edit the Code field, press the up-arrow key to position the cursor at that field.

2. Description

Required field of 3 to 45 characters that describes the reason for this block during batch enrollment.

File the code

Enter another code or exit the option

- **Functionality Interactions**

None

- **Troubleshooting**

If an enrollment block reason cannot be found during the batch enrollment process, review this file to ensure the block reason was entered.

2.1.1.9 Enrollee Lockout Override Reason Enter/Edit (LORE)

Menu Path: PAS System Menu → M → FMCP → ETAB → LORE

- **Security Keys**

CPZ CCP
CPZ FILE

- **Required Fields**

MCP Enrollee Lockout Override Reason
Description

- **Application Description**

This option allows you to enter new override reasons for booking a specialty care appointment without authorization or booking a primary care appointment with a provider other than the enrolled patient's PCM.
Enrollee lockout refers to CHCS functionality that allows a facility to define when a user can appoint enrollees to a provider in a clinic (enrollee lockout switch). It also defines a clinic as providing specialty care, primary care, or both. When the switch is activated, a user cannot appoint enrollees for primary care clinics to a provider other than the patient's PCM, unless the user overrides. The option records override information, including the user name, reason for override, and date. If an override is not entered, the system displays the PCM name and phone number, and a screen message tells the clerk to inform the patient to either make an appointment with the patient's PCM or to obtain PCM authorization.
PAS uses enrollee lockout to prevent a TRICARE Prime enrollee from being booked to a clinic other than the patient's own PCM or from being booked for specialty care without an appointment referral. PAS users may override the lockout, but must enter a reason code for doing so. Enter the PAS codes to override the lockout to use this menu option.

- **Business Rules**

– The MTF must decide if more reasons are needed.
– An override reason must be entered every time a PAS user overrides the enrollee lockout message.

- **Other Important Considerations**

The MTF must decide if enrollee lockout will be used. You must review the file to determine if additional entries are required.

- **Data Entry Process**

Enter a new enrollee lockout override reason code

Access the LORE option

Enter the enrollee lockout override reason code

Complete the MCP Enrollee Lockout Override Reason Enter/Edit screen

File the data

Enter a new code or exit the option

Access the LORE option

Enter the enrollee lockout override reason code

Enter the new enrollee lockout override reason code at the *Select ENROLLEE LOCKOUT OVERRIDE REASON* prompt. Enter a double question mark (??) to display the following picklist:

AEP	AIR EVACUATION PATIENT
AOP	AUTHORIZATION OTHER THAN PCM
EBN	ENHANCED BENEFIT
EMR	EMERGENCY
PNA	CM NOT AVAILABLE

Existing codes cannot be edited, but you can enter new codes if required.

The system displays the MCP Enrollee Lockout Override Reason Enter/Edit screen with the cursor at the code field. Refer to Figure 2-11. MCP Enrollee Lockout Override Reason Enter/Edit Screen, page 2-43.

Complete the MCP Enrollee Lockout Override Reason Enter/Edit screen

```
MCP ENROLLEE LOCKOUT OVERRIDE  MCP ENROLLEE LOCKOUT OVERRIDE REASON ENTER/EDIT


             MCP ENROLLEE LOCKOUT OVERRIDE REASON ENTER/EDIT
 ======================================================================

               Code: EMR
        Description: EMERGENCY
```

Figure 2-11. MCP Enrollee Lockout Override Reason Enter/Edit Screen

1. Code

Edit or press <Return> to verify the code.

2. Description

Required field of 3 to 45 characters. Enter a reason why the user may override the lockout and book an enrollee. Press <Return> to verify that this is the correct description

File the data

Enter a new code or exit the option

- **Functionality Interaction**

Refer to the Application Description, page 2-41.

- **Troubleshooting**

If an override code is not found when attempting to override the lockout, review this file to ensure the entry exists.

2.1.1.10 Enrollee DMIS ID Update (DMIS)

Menu Path: PAS System Menu → M → FMCP → ETAB → DMIS

- **Security Keys**

CPZ CCP
CPZ FILE
CPZ PARAMETERS

- **Required Fields**

None

- **Application Description**

This option is used to send updated enrollment transactions to DEERS for either all or specified division(s). DEERS then records the DMIS ID of the enrolling division on the patients' enrollment records. Beginning with CHCS Version 4.6, the patient's enrolling division is always the patient's assigned PCM place of care.
With CHCS Version 4.5, the system transmits the DMIS ID of the enrolling division to DEERS for all existing and new enrollments. This option updates all existing enrollments on a one-time basis. This option should be required by exception only and does not exist in CHCS versions prior to 4.5.
If the DMIS ID of an enrolling division changes, this option may be used to update DEERS as to all enrollments in that division.
Beginning with CHCS Version 4.5, the DMIS IDs of all medical center divisions cannot be edited.

- **Business Rules**

– Use this option to initially transmit the DMIS ID of each patient's enrolling division to DEERS. After the initial transmittal, the only action will be individual patient updates as enrolling divisions are corrected.
– After the initial transmission, use this option only if the DMIS ID of an enrolling division changes.
– This option does not have a file and table build.
– Warn Information Management Department or computer room personnel that this option will transmit enrollment transactions to DEERS for all TRICARE enrollees and will affect system performance and eligibility checking.
– Verify the DMIS ID with DEERS and Electronic Data Systems (EDS) before the initial tasking to ensure CHCS and DEERS have the same DMIS ID for each division in their files.

- **Data Entry Process**

Update the DMIS ID

Access the DMIS option

Select an action on the Enrollee DMIS ID Update screen

File the data

Exit the option

Access the DMIS option

Select an action on the Enrollee DMIS ID Update screen

Refer to Figure 2-12. Enrollee DMIS ID Update Screen, page 2-46.

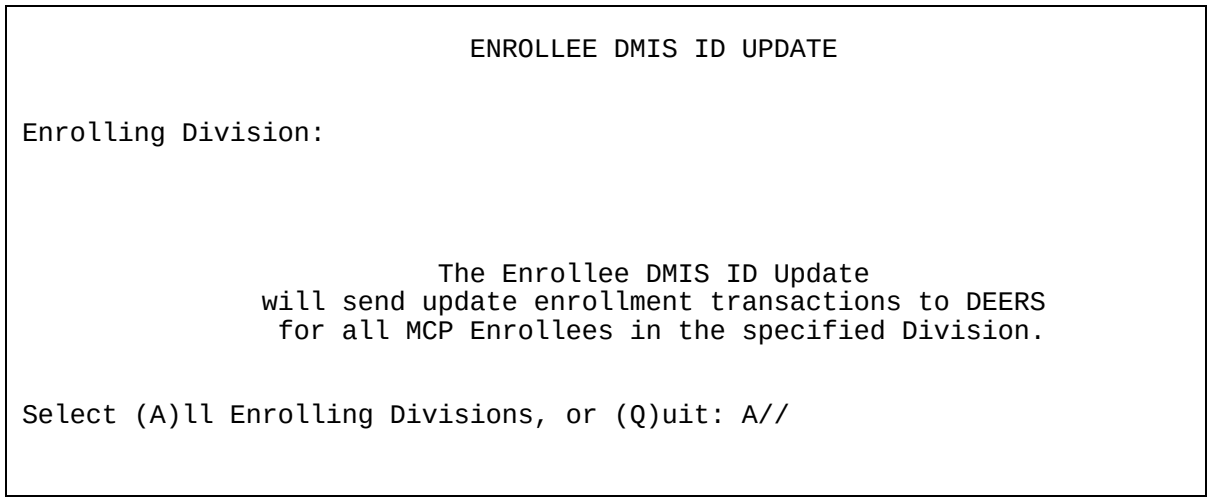


Figure 2-12. Enrollee DMIS ID Update Screen

For an initial action, the following action bar displays:
Select (A)ll Enrolling Divisions, or (Q)uit: A//
Press <Return> to accept the default A for (A)ll Divisions.
Initially, if you accept the default (A)ll action, a message states that the process is resource intensive and asks whether you want to continue. The system then begins the task and continues until complete.
For a subsequent action, the following action bar displays:
Select (A)ll Enrolling Divisions, (O)ne Enrolling Division or (Q)uit: O//
Press <Return> to accept the default O for (O)ne Enrolling Division.
In subsequent taskings, you receive the prompt for (O)ne followed by the prompt to select the enrolling division to process. The middle screen displays the message that the process transmits updated enrollment transactions for all TRICARE enrollees.
File the data
Exit the option

- **Functionality Interactions**

DEERS and CHCS must have the same DMIS ID of each enrolling division in their tables. Verify before tasking.

- **Troubleshooting**

After CHCS Version 4.5 is installed, if the DMIS ID is wrong for a division, the DMIS ID may be changed only with Support Center help. You can only send the DMIS ID of the patient's enrolling division (i.e., the DMIS ID of the patient’s assigned PCM’s place of care) in CHCS to

DEERS through this option. This option does not change a patient's enrolling division.

2.1.1.11 Clean Up DMIS ID Update (CLUP)

Menu Path: PAS System Menu → M → FMCP → ETAB → CLUP

- **Security Keys**

CPZ CCP
CPZ FILE
CPZ PARAMETERS

- **Required Fields**

None

- **Application Description**

This option is used to reset the system in the event the DMIS ID update process fails to finish due to a system crash or a TaskMan error. This option stops the job previously scheduled and allows you to restart the DMIS ID update process from the beginning.

- **Business Rules**

– Use this option only if the DMIS ID update process fails.

- **Other Important Considerations**

Use this option only to correct a failed DMIS ID update process.

- **Data Entry Process**

Restart the DMIS ID update

Access the CLUP option

Restart the DMIS ID update process

Exit the option

Access the CLUP option
After you access this option, a message states that this option is to be used when the DMIS ID update process has failed and that this option will reset it to the beginning.
Restart the DMIS ID update process
No data is affected by sending another update action to DEERS. Simply restart the option.
Exit the option

- **Functionality Interaction**

None. No data entry or file and table build is associated with this option.

- **Troubleshooting**

This option is a troubleshooting option for the DMIS ID update process. If this option does not restart the process, call the Support Center.

2.1.2 Facility File/Table Maintenance (FTAB)

Menu Path: PAS System Menu → M → FMCP → FTAB

```
   DIVI   MCP Division Profile Edit
   OFFI   MCP Office Enter/Edit
   HEAL   MCP Health Care Finder Profile Enter/Edit
   ZIPC   ZIP Code Combinations Enter/Edit
   CAZC   Catchment Area Zip Code Enter/Edit
   FACI   Facility Type Enter/Edit
   ISSO   NAS Issuing Officer Enter/Edit
   PARA   MCP Parameters Profile Enter/Edit
   UICP   UIC/PCM Maintenance Enter/Edit
   RACT   Reactivate MCP Enrollment
   MCSC   Managed Care Support Contractor Interface Menu

Select Facility File/Table Maintenance Menu Option:
```

Figure 2-13. Facility File/Table Maintenance Menu

- **Site Definable Parameters**

The MCP enrollment mode for all divisions must be set through the MCP Parameters Profile Enter/Edit (PARA) option. It is NOT division specific.

The host division on the platform must have the MCP Division field set to "YES" in the division profile. All other divisions must leave this field blank. In CHCS Version 4.4 and earlier, the DMIS ID of the MCP division is stored on patient records in CHCS. In CHCS Version 4.5, the DMIS IDs of the patients' enrolling divisions are transmitted to DEERS and are seen on their enrollment history. In CHCS Version 4.6, the enrolling division is the location of the patient's assigned PCM.

The file build sequence for new sites should be as follows:

1. MCP Division Profile Edit (DIVI). Refer to Section 2.1.2.1, page 2-50.
2. MCP Parameters Profile Enter/Edit (PARA). Refer to Section 2.1.2.8, page 2-76.
3. MCP Office Enter/Edit (OFFI). Refer to Section 2.1.2.2, page 2-54.
4. MCP Health Care Finder Profile (HEAL). Refer to Section 2.1.2.3, page 2-59.

5. UIC/PCM Maintenance Enter/Edit (UICP). May only be built after the provider network has been built in the Group Profile/Agreements Enter/Edit (GNET) option. Refer to Section 2.1.2.9, page 2-84.
6. The remaining files require no special execution sequence other than completion before activation, except for the file built in the UICP option.

2.1.2.1 MCP Division Profile Edit (DIVI)

Menu Path: PAS System Menu → M → FMCP → FTAB → DIVI

- **Security Keys**

CPZ CCP
CPZ FILE

- **Required Fields**

Medical Center Division
Facility
Division
Abbreviation

- **Application Description**

This option allows you to edit or view the division profiles within the facility and to specify which division will be designated the MCP division. The data includes all division-specific data for the MTF.

- **Business Rules**

– Designate only one division as the MCP division.
– If you can access this option, designate the MCP division as an allowable division in your user file.
– To enter data, sign on to the MCP Division. Your default division is where you are currently signed on.
– Associate the MCP division with the Site ID in the DEERS site parameters.
– You cannot create new divisions through this option. DBA systems personnel should build new divisions through the common files.
– Press <Return> to advance through all fields and enter necessary data to establish software pointer relationships.
– Do not change existing data. Refer data changes to the DBA for resolution through common files.
– Enter data only in the MCP Division field. Bypass any other blank field by using the down-arrow key to move the cursor.

- **Other Important Considerations**

This field is meant for use by the TRICARE civilian network.
The site must decide which division will be the MCP division. One division should not make the decision for others. Normally, the host site will be designated the MCP division. In CHCS Version 4.4, the DMIS ID of the MCP division is transmitted to DEERS for enrollments. In CHCS Version 4.5, the DMIS ID of each patient's enrolling division is transmitted to DEERS.
Once the MCP Division field has data, the site should consider locking the DIVI option with a site-specific security key to prevent any inadvertent data changes affecting the entire site.

- **Data Entry Process**

Enter a new MCP division

Access the DIVI option

Access the correct division

Complete the SD Division Profile screen

File the data

Exit the option

Access the DIVI option
Access the correct division
When you access this option, the division where you signed on is the default. Refer to Figure 2-14. MCP Division Name Prompt, page 2-52. If no default displays or you are not sure, you may enter a double question mark (??) at the *Select MEDICAL CENTER DIVISION NAME* prompt to display available divisions.

```
MCP Division Profile Edit

Select MEDICAL CENTER DIVISION NAME: DIV A - TRAINING HOSPITAL//
```

Figure 2-14. MCP Division Name Prompt

Complete the SD Division Profile screen
After you enter the division name, the system displays the SD Division Profile screen. Refer to Figure 2-15. SD Division Profile Screen, page 2-53.

```
MEDICAL CENTER DIVISION: DIV A - TRAINING HOSPITAL   SD DIVISION PROFILE

               Facility: TRAINING MEDICAL TREATMENT FACILITY
               Division: DIV A - TRAINING HOSPITAL
           Abbreviation: DIVA
          Building Name:
        Building Number:
         Street Address: 1610 CONSTITUTION AVE
                    ZIP: 20307
                   City: WASHINGTON
                  State: DISTRICT OF COLUMBIA
    Patient Record Pull: 1     day(s)
  Radiology Record Pull: 1  day(s)
 Schedule Hold Duration: 2  day(s)
         PAS Mail Group:
          Group ID Code: 0037
           DMIS ID Code: 0037
           MCP Division: YES
  Default to remind Patients of other Appts/Wait List Requests: YES
Enable DX/PX Coding for Outpatient Encounters in this Division:
```

Figure 2-15. SD Division Profile

Press <Return> to advance through all fields except the MCP Division field, to establish software pointers. All other divisions should be set to "NO" or left blank.
Enter "YES" at the MCP Division field.
The MCP Division is intended for use by non-MTF clinics (civilian places of care).
DO NOT change any other field. Contact the DBA if another field appears to be incorrect.
Workload reports are broken down by division.
File the data
Exit the option

- **Functionality Interactions**

The DIVI option accesses a common file that directly affects all functionalities. This option must not be used for practice in the "live system."
DEERS interacts frequently with MCP and affects all TRICARE enrollments. The DMIS ID in this menu should never be changed by users in CHCS Versions 4.4 and earlier. The DMIS ID is uneditable in CHCS Version 4.5.

- **Troubleshooting**

Very few problems of significance have been associated with an incorrectly set MCP Division flag. Problems have occurred as a consequence of users changing site/PAS parameters through this option. Access to this option should be severely limited or denied once the MCP

division flag is set. Some associated problems are noted below.

Problem – Incorrect division designated the MCP division locally. Does not affect enrollments because the DEERS site ID dictates which division DMIS ID is used.

Solution – Access the incorrect division and change the MCP division to "NO." After you exit this division, access the correct division and enter "YES" at the MCP Division field.

Problem – DMIS ID used by the MCP division is invalid or deactivated in DEERS. Patients' enrollments are coded Invalid in CHCS.

Solution – Contact the Support Center.

Problem – DMIS ID incorrectly mapped by EDS to the DEERS site ID. MCP enrollments are invalid in CHCS due to reason "Invalid Site ID."

Solution – Ask systems personnel to initiate a trouble call with EDS (DEERS).

Problem – Unable to change the MCP Division field from "NO" to "YES."

Solution – Find the division with the MCP Division field set to "YES" and change it to "NO." Return to the correct division and enter "YES."

2.1.2.2 MCP Office Enter/Edit (OFFI)

Menu Path: PAS System Menu → M → FMCP → FTAB → OFFI

- **Security Keys**

CPZ FILE
CPZ CCP

- **Required Fields**

MCP Office
MCP Office Supervisor

- **Application Description**

This option is used to create MCP TRICARE offices for the HCFs or the persons/offices responsible for booking appointments, issuing CAFs, processing batch PCM reassignments, and sending renewal/disenrollment letters. The MTF may refer to these offices as service centers or any other designation. More than one "MCP office" may be created. Each office has a supervisor.

- **Business Rules**

– You may create any number of MCP/TRICARE offices.
– Use this option to build only offices that book appointments, issue CAFs, process batch PCM reassignments, and send renewal/disenrollment letters.
– Add the supervisors to the User file. The same person may be a supervisor in more than one office.

- **Other Important Considerations**

The MTF must decide how many and which offices are allowed to issue CAFs, process batch PCM reassignments, and send renewal/disenrollment letters.
Will the MTF or TRICARE contractors issue CAFs when a PCM refers a patient to a specialist, outside provider, or non-network provider?

- **Data Entry Process**

Enter a new TRICARE/MCP office

Access the OFFI option

Enter the name of the TRICARE office

Complete the CP Office Profile screen

File the data

Enter a new office or exit the option

Access the OFFI option
Enter the name of the new TRICARE office

At the *MCP Office* prompt, enter the name you wish to assign to your office. Enter the name of the new TRICARE office or of an existing office to edit. That name prints on CAFs issued by this office.

After you enter the TRICARE office name, the CP Office Profile screen displays. Refer to Figure 2-16. CP Office Profile Screen, page 2-57.

Complete the CP Office Profile screen

```
MCP OFFICE: OFFICE OF HEALTH CARE FINDER                CP OFFICE PROFILE

 MCP OFFICE: OFFICE OF HEALTH CARE FINDER
 MCP OFFICE SUPERVISOR: JESSUP,GEORGE
 STREET ADDRESS: 678 DUPONT CIRCLE
 ZIP: 20307
 CITY: WASHINGTON
 STATE: DISTRICT OF COL
 OFFICE PHONE: (442)234-0987
 OFFICE LOCATION:
 OFFICE HOURS: M-F 9-5




Ask for Help = HELP     Screen Exit = F10     File/Exit = DO   INSERT OFF
```

Figure 2-16. CP Office Profile Screen

1. MCP Office

Required field and the name given to the TRICARE office you are creating (e.g., Managed Care Office). The name entered prints on CAFs, batch reassignment notifications, or renewal/disenrollment letters.

2. MCP Office Supervisor

Required field that should contain the name of the supervisor for this office. That name must be in the User file.

3. Street Address

Optional, free-text field. Enter the address for the MTF office.

4. ZIP

Optional field. Enter the ZIP code where the office is located. This should be a valid ZIP code recognized in CHCS. Once a ZIP code is entered, the system automatically fills the City and State fields.

5. City

Defaults from the ZIP code when a valid ZIP code is entered. This field may also contain a free-text entry.

6. State

Defaults from the ZIP code but may also be a free-text entry.

7. Office Phone

Optional, free-text field. The office phone number that prints on the CAF if data is entered.

8. Office Location

Optional, free-text field where you can enter a description of the office is location (e.g., 3rd Floor, Ste. A). This information does not print on the CAF.

9. Office Hours

Optional, free-text field and does not print on the CAF.

File the data

Enter a new office or exit the option

- **Functionality Interactions**

This file does not affect any other functionality in CHCS. The only processes affected in MCP by this office(s) are printing CAFs which may be used to authorize care with civilian providers, notification letters of PCM reassignment, and TRICARE renewal or disenrollment notices.

- **Troubleshooting**

If the MCP office information does not appear on the CAF or notification letters, ensure that the office data has been entered in CHCS.

2.1.2.3 MCP Health Care Finder Profile Enter/Edit (HEAL)

Menu Path: PAS System Menu → M → FMCP → FTAB → HEAL

- **Security Keys**

CPZ CCP
CPZ FILE

- **Required Fields**

Health Care Finder

- **Application Description**

This option is used to enter the names of the HCFs associated with all MCP offices and whose names print on the CAFs.

- **Business Rules**

– The names of the HCFs must exist in the CHCS User file.
– The MCP office for the HCFs must be built first.

- **Other Important Considerations**

If the MTF plans to use CAFs, the Health Care Finder file should be built.
The MTF must decide who may be designated HCFs. Only those users who issue CAFs should be in this file regardless of their title.

- **Data Entry Process**

Enter a new HCF

Access the HEAL option

Enter the HCF name

Complete the CP HCF Profile screen

File the data

Enter a new HCF or exit the option

Access the HEAL option
Enter the HCF name
At the *Select HEALTH CARE FINDER* prompt, enter the name of the person who will be an HCF. This name must already exist in the CHCS User file.
The system displays the CP HCF Profile screen. Refer to Figure 2-17. CP HCF Profile Screen, page 2-60.
Complete the CP HCF Profile screen
This screen collects data on valid HCFs.

```
MCP HCF: PENNY,ALEX N                                        CP HCF PROFILE

 HCF: PENNY,ALEX N
 HCF PHONE:
 MCP OFFICE: OFFICE OF HEALTH CARE FINDER


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO   INSERT OFF
```

Figure 2-17. CP HCF Profile

1. HCF

Edit or press <Return> to verify the name of the HCF.
The HCF field defaults with the name entered at the *Select HEALTH CARE FINDER* prompt. This is a required field and must be a name already existing in the User file.

2. HCF Phone

Optional, free-text field.

3. MCP Office

This field should be defined through the MCP Office (OFFI) option. If no office is entered, the name of the HCF does not appear in the HCF file.

File the data

Enter a new HCF or exit the option

- **Functionality Interaction**

The names entered in this menu option must exist in the User file. Also, the names cannot be edited and changed through this option.

No other functionality of CHCS is affected by this file. The names of HCFs who actually book the appointment for either primary or specialty care display on the appropriate CAFs.

- **Troubleshooting**

If a HCFs name does not appear on the CAF, ensure a valid office is entered for that HCF in this menu option.

2.1.2.4 ZIP Code Combinations Enter/Edit (ZIPC)

Menu Path: PAS System Menu → M → FMCP → FTAB → ZIPC

- **Security Keys**

CPZ CCP
CPZ FILE

- **Required Fields**

ZIP Code Combination
Code

- **Application Description**

This option allows you to create and edit ZIP code combinations under a unique name. This unique combination of ZIP codes can then be used in TRICARE (MCP) booking and PCM assignment options as a search criteria for providers rather than searching by individual ZIP codes.

- **Business Rules**

– ZIP codes used must be valid in CHCS.

– To create a combination, you must enter both a unique name and the ZIP codes you desire included under that ZIP code combination.

- **Other Important Considerations**

ZIP code combinations may be used to aid in a provider search in the PCM assignment and MCP booking options.

The MTF must decide what combinations to use, and ZIP codes to include. Combinations are not necessary for MCP to function, but are a valuable tool for provider searches.

- **Data Entry Process**

Enter a new ZIP code combination

Access the ZIPC option

Enter the name of the ZIP code combination

Complete the CP ZIP code combinations screen

File the data

Enter another ZIP code combination or exit the option

Access the ZIPC option

Enter the name of the ZIP code combination

When you enter a name for the combination (e.g., NORTH SAN DIEGO), the CP ZIP Code Combinations screen displays. Refer to Figure 2-18. CP ZIP Code Combinations Screen, page 2-64.

Complete the CP ZIP Code Combinations screen

```
MCP ZIP CODE COMBINATIONS: BETHESDA              CP ZIP CODE COMBINATIONS

                  Identifier: BETHESDA
 Programmer Access Required:

 Code    City                                     State
  20814  BETHESDA                                 MARYLAND
  20815  CHEVY CHASE                              MARYLAND
  20816  BETHESDA                                 MARYLAND
  20817  BETHESDA                                 MARYLAND
  20824  BETHESDA                                 MARYLAND
  20825  CHEVY CHASE                              MARYLAND
  20827  BETHESDA                                 MARYLAND



Ask for Help = HELP     Screen Exit = F10     File/Exit = DO   INSERT OFF
```

Figure 2-18. CP ZIP Code Combinations Screen

1. Identifier

Defaults from the ZIP code combination name entered on the previous screen and can be edited at any time.

2. Programmer Access Required

Bypassed field.

3. Code

The cursor is positioned under the word "Code." Press <Return> once to move the cursor one space to the right.
Enter a valid ZIP code.
To enter a second and succeeding ZIP codes, repeat the procedure.
The number of ZIP codes allowed in a combination is unlimited.

4. City and State

Default from the ZIP code entered.
ZIP codes may be added or deleted in the CP ZIP CODE COMBINATIONS screen. To delete a ZIP code:

– Place the cursor on the code to delete.
– Press the remove/delete key or press <PF1>, then the backspace/delete key.

File the data
Enter another ZIP code combination or exit the option

- **Functionality Interactions**

None

- **Troubleshooting**

If a provider in a particular area fails to display during a search, review this file to determine whether the provider's

office (place of care) ZIP code is contained in a combination.

2.1.2.5 Catchment Area ZIP Code Enter/Edit (CAZC)

Menu Path: PAS System Menu → M → FMCP → FTAB → CAZC

- **Security Keys**

CPZ CCP
CPZ FILE
CPZ ZIP*

* This security key is not necessary to enter or edit data. It is necessary only if users are allowed to override residential enrollment restrictions set through the MCP Parameters Profile Enter/Edit (PARA) option and through this option. Refer to Section 2.1.1.8 Enrollment Block Reason Enter/Edit (EBRE), page 2-37.

- **Required Fields**

ZIP Code

- **Application Description**

This option allows you to define your catchment area by ZIP code as well as to define and edit your patient enroll and provider network areas. You may define multiple catchment areas if you are in an overlapping catchment area.

- **Business Rules**

– When a patient is enrolled, CHCS screens the patient's address for an allowable ZIP code if the MCP Parameters Profile Enter/Edit (PARA) option is set to restrict enrollment by residential address.

– You may establish the provider network within a specified area if defined here.

- **Other Important Considerations**

The catchment area for the MTFs may be defined here, but must be for all MTFs using this CHCS network and CHCS host. It is not site- or division-specific.

This option is used in conjunction with the site parameters to restrict TRICARE enrollments. Refer to Section 2.1.2.8 MCP Parameters Profile Enter/Edit (PARA), page 2-76.

The MTF must decide if TRICARE Prime enrollment will be restricted to patients residing within a defined area. The defined area may be expanded by adding ZIP codes.

CHCS must contain the local address of patients rather than their established home of record. This prevents patient

enrollment if this option is activated and they live outside the area.
If more than one MTF is on the local network, use of this option must be coordinated because it will affect all users.
This option is not site- or division-specific.
Although not designed to affect other functionalities, other CHCS functionalities at some MTFs have used this option to create catchment areas prior to MCP activation. They used ad hoc reports to generate reports of value to themselves. If you plan to use this option and another department has already been using it, you should inform that department of possible changes.

- **Data Entry Process**

Enter a new catchment area ZIP code

Access the CAZC option

Enter a valid ZIP code to include in the catchment area

Complete the DOD ZIP Code Enter Edit screen

File the data

Enter a new ZIP code or exit the option

Access the CAZC option
Enter a valid ZIP code to include in the catchment area
When you enter a valid ZIP code within the catchment area you wish to define at the *Select ZIP CODE* prompt, the DOD ZIP Code Enter Edit screen displays. Refer to Figure 2-19. DOD ZIP Code Enter Edit Screen, page 2-68.

Complete the DOD ZIP Code Enter Edit screen

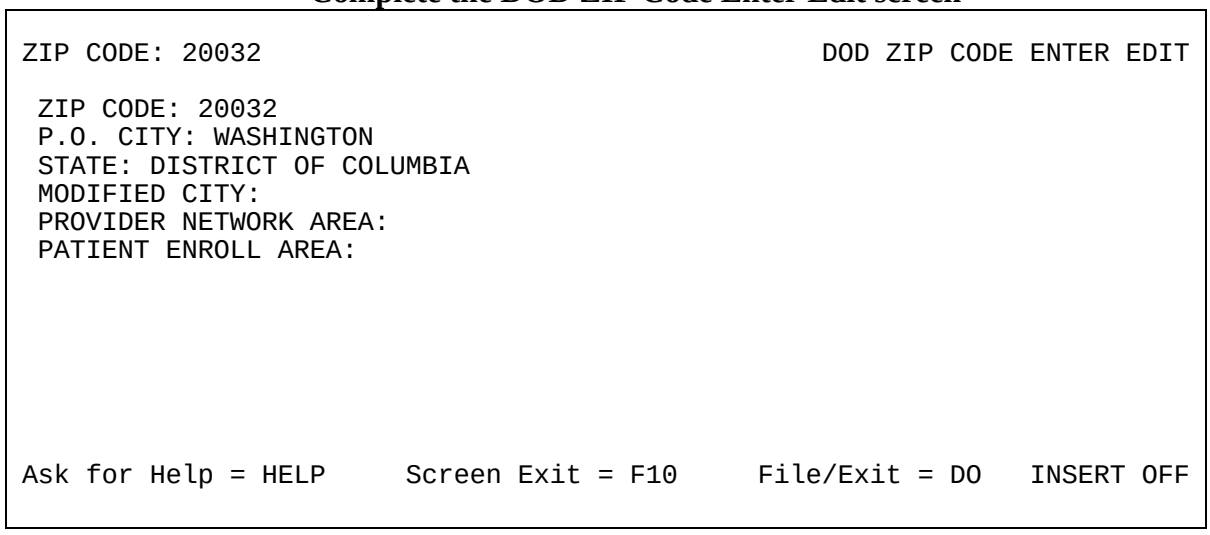


Figure 2-19. DOD ZIP Code Enter Edit Screen

1. ZIP Code

Defaults to the ZIP code you entered previously.

2. P.O. City

Defaults the name of the ZIP code of the corresponding city. Cannot be edited.

3. State

Defaults the name of the state from the ZIP code. Cannot be edited

4. Modified City

Edit the City field or use as an alternate for the P.O. City field since that field cannot be edited.

5. Provider Network Area

Allows you to define by provider place of care (clinic) ZIP code, those providers who are part of the MCP provider network. Optional field. Enter either “YES” or “NO” and edit at any time. If no data is entered, “NO” is the default.

6. Patient Enroll Area

Patients’ home residence ZIP codes, which are part of the patient enrollment area for the TRICARE program (MCP). If the MCP Parameters Profile Enter/Edit (PARA) option is set to "restricting enrollments by residential address," ZIP codes defined here screen patient enrollments to allow enrollment/empanelment only within the ZIP codes entered here.

Optional field. Enter “YES” or “NO,” and edit at any time, or leave blank.

File the data

Enter a new ZIP code or exit the option

- **Functionality Interactions**

Refer to Other Important Considerations.

- **Troubleshooting**

Problem – This file should be blank initially. If entries exist, functionalities other than MCP may have used it for other purposes.
Solution – This file is editable and should be changed to correctly reflect the MTF catchment area.
Problem – Users performing enrollments may receive a message that the patient's ZIP code is Invalid.
Solution – Look at that patient's ZIP code in this option to verify whether the ZIP Code is set to "YES" and if the MCP Parameters Profile Enter/Edit (PARA) option restricts residential enrollment. If so, review the patient's home address in CHCS and determine if it is a local or home of record address.
Problem – Users performing enrollments are unable to enroll patient after ZIP codes are defined and restricted in the PARA option.
Solution – User may not possess the CPZ ZIP security key.

2.1.2.6 Facility Type Enter/Edit (FACI)

Menu Path: PAS System Menu → M → FMCP → FTAB

- **Security Keys**

CPZ CCP
CPZ FILE

- **Required Fields**

Facility Type
Description

- **Application Description**

This file contains entries used to describe a place of care (clinic) in MCP. The file comes already populated with entries, but new ones may be added. Entries from this file are required when building an MCP place of care, but is an informational field only. Existing entries can be inactivated but not deleted.

- **Business Rules**

– Designate a place of care that sees all types of patients as a Multi-service (MSC) facility.
– Designate a place of care that sees only one type of patient (e.g., Cardiology) as a single service (SSC) facility.
– Designate all other facilities according to their description.

- **Other Important Considerations**

Determine if more facility types should be added to the MCP Facility Type file. You may print the file as an ad hoc report by using the FileMan Print option. Print the MCP Facility Type file, sorting by code and printing the code and description.

This file may be used later to report on the different types of facilities to which you refer patients.

- **Data Entry Process**

Enter a new facility type

Access the FACI option

Enter the facility type Name

Complete the MCP Facility Type screen

File the data

Enter another facility type or exit the option

Access the FACI option

Enter the facility type name

At the *Select FACILITY TYPE* prompt, enter a 2 to 3 character code to describe the facility and verify that it is a new facility type. The system displays the MCP Facility Type screen. Refer to Figure 2-20. MCP Facility Type Screen, page 2-72.

Complete the MCP facility type screen

```
MCP FACILITY TYPE: AMB                                    MCP FACILITY TYPE

                      MCP FACILITY TYPE ENTER/EDIT
 ==========================================================================

               Code: AMB
        Description: AMBULANCE SERVICE









Ask for Help = HELP     Screen Exit = F10     File/Exit = DO   INSERT OFF
```

Figure 2-20. MCP Facility Type Screen

1. Code

Verify the name of the facility type.

2. Description

Free-text field that is an expansion of the code and describes the facility.

You may edit existing entries by entering the code.

File the data

Enter another facility type or exit the option

- **Functionality Interactions**

None

- **Troubleshooting**

This file usually does not present any problems and may be edited at any time.

2.1.2.7 NAS Issuing Officer Enter/Edit (ISSO)

Menu Path: PAS System Menu → M → FMCP → FTAB → ISSO

- **Security Keys**

CPZ CCP
CPZ FILE

- **Required Fields**

NAS Issuing Officer Name
Title
Military Rank OR Civilian Rank

- **Application Description**

The person(s) authorized to sign non-availability statements (NASs) must be entered in this file. Only names

entered here are available as the issuing officer(s) on a NAS.

- **Business Rules**

– Enter only persons authorized by the hospital commander to sign NASs in this file.

– The person authorized to sign the statements may also be the same one creating an NAS in CHCS.

– The persons entered here do not need to be in the CHCS User file.

– The MTF must decide who is authorized to sign an NAS. Persons currently authorized to do so may continue as long as their names are entered into this file.

– This file is blank prior to activation and must be built prior to activating the use of NAS through CHCS.

- **Other Important Considerations**

None

- **Data Entry Process**

Enter a new issuing officer

Access the ISSO option

Enter the name of the new issuing officer

Complete the MCP NAS Issuing Officer screen

File the data

Enter a new issuing officer name or exit the option

Access the ISSO option

Enter the name of the new issuing officer

At the *Select NAS ISSUING OFFICER* prompt, enter the name of the person authorized to sign NASs. Enter the last name first, and then the first name and middle initial (e.g., SMITH,JOHN A). Upper case or lower case is satisfactory, but be sure of the spelling. DO NOT enter a space between the comma and the first name and DO NOT put a period after the middle initial.

Once filed, the name cannot be edited, inactivated, or deleted using this option.

At the *NAS ISSUING RANK* prompt, enter a military rank or CIVILIAN preceded by a service affiliation (e.g., NCIVILIAN for navy affiliated civilians). In the case of a non-service affiliated civilian, enter XCIVILIAN. Do not enter anything in this field for a civil service rate.

Complete the MCP NAS Issuing Officer screen

```
NAS ISSUING OFFICER: JOHNSON,RICHARD                    MCP NAS ISSUING OFFICER

                      NAS ISSUING OFFICER ENTER/EDIT
================================================================================
 Name:             JOHNSON,RICHARD

 Title:            ADMIN OFFICER

 Military Rank:    COLONEL                          Civilian Rank:




Ask for Help = HELP     Screen Exit = F10     File/Exit = DO          INSERT OFF
```

Figure 2-21. MCP NAS Issuing Officer Screen

1. NAME

Defaults to the first field.

2. Title

Required field. The entries for this file are already stored in CHCS but may be added to if the title you enter is not contained in CHCS. If not in the files, the system verifies by displaying the new title in the middle Select Window, and asking if you are adding a NEW TITLE. If a new title, verify it is new.

3. Military Rank

Defaults from the previous screen if entered. In the case of civil service employees, bypass this field by pressing <Return>.

4. Civilian Rank

Enter the appropriate GS rank for Civil Service personnel (e.g., GS07). Leave this field blank for military personnel.

File the data

Enter a new issuing officer name or exit the option

- **Functionality Interaction**

You may add to the CHCS Title file only if you have the FileMan code "#".

This option uses entries from the CHCS Military Grade Rank and the Federal Civil Service Paygrade files.

The Issuing Officer field is mandatory when entering an NAS in CHCS and is included in every NAS transaction to DEERS.

- **Troubleshooting**

Problem – Unable to display a name while trying to issue a NAS.
Solution – Check this file to ensure entries have been made.
Problem – A user is unable to enter a new title while entering the name of an issuing officer.
Solution – Review that user's CHCS account for the proper FileMan code.
Problem – An issuing officer's name is misspelled.
Solution – The DBA must correct the name through FileMan.

2.1.2.8 MCP Parameters Profile Enter/Edit (PARA)

Menu Path: PAS System Menu → M → FMCP → FTAB → PARA

- **Security Keys**

CPZ CCP
CPZ FILE
CPZ PARA
CPZ ZIP*
* Users who hold this security key can override the residential restrictions set here.

- **Required Fields**

Enrollment Mode
Hours for Running Batch Enrollment*
Day of Month to Perform Monthly Eligibility Checks*
Date to Perform Annual Eligibility Checks*
* Not system required, but necessary for MCP to function correctly.

- **Application Description**

This option allows you to enter and edit MCP enrollment parameters for the local CHCS network. It allows you to designate whether to operate in Local Empanelment mode or full DEERS Enrollment mode, restrict enrollment by residential address, and/or by patient category. It also establishes hours for running batch enrollments and dates for annual active-duty eligibility checks.

- **Business Rules**

– If DEERS Enrollment mode is used, DEERS enrollment transactions occur for all patient categories.
– If Local Empanelment mode is used, a DEERS enrollment transaction is transmitted only for active-duty patients and Medicare patients (ACV = D).

– Set the MCP Division field to "YES" in the designated division in order to access the MCP Parameters Profile Enter/Edit (PARA) option. Refer to Section 2.1.2.1 MCP Division Profile Edit (DIVI), page 2-50.
– A site-defined parameter is created, starting with zero days with a range of seven days minimum, 120 days maximum. The zero setting provides sites with the capability to not apply a grace period. The site-defined parameter defaults to a maximum of 120 days. **Note:** You may <Return> through fields in the PARA option to activate the grace period.
– Active-duty beneficiaries with an ACV of “A” are eligible for grace period processing. Grace period value is set in the MCP Parameters Profile Enter/Edit (PARA) option.
– Non-active-duty beneficiaries with an ACV of “E” are eligible for grace period processing.
– The system performs automatic DEERS eligibility checks seven days prior to and on the day of grace period disenrollment for active-duty beneficiaries.
– The system updates CHCS MCP End Enroll Date with the DEERS Eligibility End Date when the active-duty beneficiaries with an ACV of “A” disenrollment enrollment grace period has expired (except in Regions 13 and 14).
– Beneficiaries with expired Enrollment End Dates within the grace period maintain the status of Enrolled and continue to display on enrollment-related reports.
– Authorized MCP users can view and use enrollment records within the grace period. The system automatically updates enrollment records within the grace period.
– MCP users with the CPZ PARAMETERS key can edit the Active Duty Disenrollment Grace Period field in the MCP Parameters Profile Enter/Edit (PARA) option.

- **Other Important Considerations**

The CHCS network must decide which enrollment mode is appropriate. Site staff should ask the regional lead agent for direction. All sites in a region should be in the same mode. If the DEERS Enrollment mode is used in CHCS, TRICARE contractors cannot enroll patients through their own system. The reverse is true if the TRICARE contractor system performs the enrollments; then CHCS is set to local empanelment mode.

DEERS transactions occur for active-duty beneficiaries and Medicare enrollees regardless of the enrollment mode used. Active-duty enrollments and Medicare are not affected by the enrollment mode and are always sent to DEERS.
If the Local Empanelment mode is used, CHCS does not update TRICARE enrollment in DEERS for non-active-duty patients. The TRICARE contractor may perform this function in this mode.
If the enrollment mode is changed from the Local Empanelment mode to DEERS Enrollment, the *Do you wish to Disenroll/Disempanel all non-active duty MCP enrollees?* prompt displays. If you answer "YES," CHCS begins the process and no enrollments can occur until the process is completed. All active-duty and Medicare enrollees remain enrolled.
If you change the enrollment mode in error, the time and effort to reenroll beneficiaries could be considerable. The security key locking this option should be severely restricted to no more than two or three people.
If the enrollment mode is changed from DEERS Enrollment mode to Local Empanelment mode, the prompts *Do you wish to disenroll all active duty enrollees?* and *Do you wish to Disenroll/disempanel all CHAMPUS-eligible TRICARE Prime non-active duty Enrollees?* display. **CAUTION: This is a very restricted area. Be careful not to disenroll all your Medicare and CHAMPUS-eligible TRICARE Prime non-active duty beneficiaries.**
Enrollment is restricted by residential address, the Catchment Area ZIP Code Enter/Edit (CAZC) option must be used to define the catchment area ZIP codes. Refer to Section 2.1.2.5 Catchment Area ZIP Code Enter/Edit, page 2-65.
The hospital commander or the Managed Care Office should decide whether enrollment is restricted by ZIP code or patient beneficiary type.

- **Data Entry Process**

Enter TRICARE program parameters

Access the PARA option

Complete the MCP Parameters Profile screen

File the data

Access the PARA option

Complete the MCP Parameters Profile screen

When you access this option, the MCP Parameters Profile screen displays. The DMIS ID of the MCP division that is mapped to the DEERS site ID by EDS defaults in the upper left-hand corner. Refer to Figure 2-22. MCP Parameters Profile Screen, page 2-80.

```
MCP PARAMETERS: 0037                                MCP Parameters Profile



 Catchment Area Name: DIV A - TRAINING HOSPITAL
 Catchment Area DMIS ID: 0037
                                    Enrollment Mode: LOCAL EMPANELMENT

         Restrict Enrollment by Residential Address: NO
 Restrict Enrollment for Active Duty Family Members: NO
      Restrict Enrollment for Retired Beneficiaries: NO
     Restrict Enrollment for Retired Family Members: NO

                 Hours for running Batch Enrollment: 2100 to 0400

 Active Duty DEERS Eligibility Parameters:

           Date to Perform Annual Eligibility Checks:
  Day of Month to Perform Monthly Eligibility Checks:
              Active Duty Disenrollment Grace Period:

Ask for Help = HELP     Screen Exit = F10     File/Exit = DO   INSERT OFF
```

Figure 2-22. MCP Parameters Profile Screen

1. Catchment Area Name

Defaults with the division previously designated as the MCP division. This field cannot be edited.

2. Catchment Area DMIS ID

Cannot be edited. Defaults with the DMIS ID of the MCP division.

3. Enrollment Mode

Determines which enrollment transactions are transmitted to DEERS. If Local Empanelment mode is used, only active-duty and Medicare transactions are transmitted to DEERS. Non-active duty and non-Medicare beneficiary transactions receive only an eligibility transaction and do not appear in DEERS as TRICARE-enrolled.

If DEERS Enrollment mode is used, an enrollment transaction is transmitted to DEERS for all patients so that patients display as enrolled in MCP/TRICARE if the enrollment is successful.

4. Restrict Enrollment by Residential Address

Normally set to "NO." If set to "YES," ZIP codes considered in the catchment area must be defined through

the Catchment Area ZIP Code Enter/Edit (CACZ) option. Refer to Section 2.1.2.5 Catchment Area ZIP Code Enter/Edit, page 2-65. Users allowed to override this restriction must be assigned the CPZ ZIP security key.

5. Restrict Enrollment for Active Duty Family Members
Normally set to "NO." If you want the restriction, this field must be changed to "YES." CHCS prevents active-duty family members from enrolling in TRICARE.

6. Restrict Enrollment for Retired Beneficiaries
Normally set to "NO." If you want the restriction, this field must be changed to YES. CHCS prevents retired beneficiaries from enrolling in TRICARE.

7. Restrict Enrollment for Retired Family Members
Normally set to "NO." If you want the restriction, this field must be changed to "YES." CHCS prevents retired family members from enrolling in TRICARE.

8. Hours for Running Batch Enrollments
Requires a start time and a stop time. The start time must be after 2100 so that CHCS is not affected during normally busy hours. The stop time must be no later than 0400 to prevent severe effects during the day. If the batch process has not finished the tasking by the stop time, the job is halted for the day and begun again the next night at the regular start time where it left off the previous night.

9. Date to Perform Annual Eligibility Checks
Requires a date for CHCS to use to identify active-duty enrollees who have been enrolled more than three years in TRICARE at your facility, send a DEERS transaction on them, and update their end eligibility date.

10. Day of the Month to Perform Monthly Eligibility Checks
Must be the date of the month when CHCS identifies and sends a DEERS transaction on active-duty enrollees whose enrollment expires the following month. If DEERS has a new eligibility date for them, their enrollment record is modified to reflect the new end enrollment date. A date after the 5th of the month and before the 25th is recommended to prevent DEERS from being overloaded with eligibility requests. If this field and the previous one are not completed, the nightly process CP Enrollment Bulletin will not update any enrollments.

11. Active Duty Disenrollment Grace Period
Allows sites to define a disenrollment grace period of zero or a minimum of seven days and a maximum of 120 days

for active-duty beneficiaries with the ACV of "A." The default is 120 days.
If zero is set in this field, sites are able to NOT apply a grace period. You must <Return> through fields in the PARA option to activate the grace period.
The system transmits a DEERS eligibility check seven days prior to the grace period expiration date and again on the grace period expiration date. When the DEERS eligibility response is received, the system updates the MCP End Enroll Date to equal the DEERS Eligibility End Date.
If an enrollment expires after the grace period, the system updates the MCP status from Enrolled to Disenrolled, enters a disenrollment reason, and sends a disenrollment transaction to DEERS.
Beneficiaries with expired end dates within the grace period maintain the MCP status of Enrolled and are included as Enrolled in the following MCP reports (refer to List of Sample Reports to find report samples):
AD Family Members by Unit Enrollment Roster
Menu Path: PAS System Menu → M → EMCP → OENR → ERPM → ROST → 1
Alphabetic Enrollment Roster by Service
Menu Path: PAS System Menu → M → EMCP → OENR → ERPM → ROST → 2
Change in Eligibility Enrollment Roster
Menu Path: PAS System Menu → M → EMCP → OENR → ERPM → ROST → 4
Disenrollees for Period by Reason Code
Menu Path: PAS System Menu → M → EMCP → OENR → ERPM → ROST → 5
Disenrollment Summary by Reason
Menu Path: PAS System Menu → M → EMCP → OENR → ERPM → SUMM → 1
Enrollment Summary Report
Menu Path: PAS System Menu → M → EMCP → OENR → ERPM → SUMM → 2
Patient Category Enrollment Summary
Menu Path: PAS System Menu → M → EMCP → OENR → ERPM → SUMM → 4
Beneficiaries with Enrollment End Dates within the grace period are included in the build utility listed below:
Family Batch Enrollment Labels Build Utility

Menu Path: PAS System Menu → M → EMCP → OENR → ERPM → LABL → 1

The Enrollment End Date is not updated by a DEERS eligibility check for Regions 13 and 14.

This functionality is applicable in both Local Empanelment and DEERS Enrollment modes.

File the data

- **Functionality Interactions**

Enrollment processing is controlled by the parameters set in this option and may affect all MCP files. Affected areas are:

Enrollments
Disenrollments
Batch Enrollments
AD Eligibility Checks
CP Enrollment Bulletin (Nightly TaskMan process)
DEERS Eligibility
TRICARE and Claims Payments
Reciprocal Disenrollments
Batch Renewal/Disenrollment Functions.

- **Troubleshooting**

Problem – Certain beneficiaries are not being enrolled.
Solution – Review this option and remove the restriction on that beneficiary type.

Problem – Batch enrollments do not appear to be working.
Solution – Review the hours for running batch AD enrollments and enter/edit the hours.

Problem – You receive a mail bulletin that the CP Enrollment Bulletin cannot run (CHCS Version 4.5).
Solution – Review the dates to perform eligibility checks and enter dates in the Date to Perform Annual Eligibility Checks and Day of Month to Perform Monthly Eligibility Checks fields. Refer to Figure 2-22. MCP Parameters Profile Screen, page 2-80 (CHCS Version 4.5 only).

Once established, these parameters should not require resetting often unless the MTF wants to restrict enrollment for certain segments of the patient population. This option is locked with the CPZ PARA security key and should be restricted.

2.1.2.9 UIC/PCM Maintenance Enter/Edit (UICP)

Menu Path: PAS System Menu → M → FMCP → FTAB → UICP

- **Security Keys**

CPZ CCP

CPZ FILE

- **Required Fields**

PCM if direct assignment
Specialty and Location if search selected
UIC

- **Application Description**

The UIC/PCM Maintenance file is used to link a PCM and the unit for which the PCM is responsible. If the link is established through this option, the system enters a defaulted PCM for active-duty patients during the enrollment process.

- **Business Rules**

– Set up the link using the standard Unit Identification Code (UIC) established by the Department of Defense (DOD) and contained in CHCS.
– One PCM can be responsible for multiple UICs.
– One UIC cannot be assigned to multiple PCMs.
– The UIC used must be in the Unit Ship ID File.
– The PCMs used here must already be designated PCMs through the Group Profile/Agreements Enter/Edit (GNET) option. Refer to Section 2.2.1.3 **GNET – Providers**, page 2-1. The PCM Provider Network must be established for this link to be established.

- **Other Important Considerations**

The MTF must decide whether to establish the UIC to PCM link. While the link can save valuable time by automatically assigning a PCM to active duty, the Unit Ship ID file must be updated and maintained.
This link is valuable only for active-duty enrollments. Non-active-duty beneficiaries must still be enrolled individually. If the MTF wants to enroll all family members to the same PCM, only the sponsor's enrollment benefits from this function.

- **Data Entry Process**

Link a PCM with a UIC (unit)

Access the UICP option

Enter the search criteria

Select the PCM to link

Add a UIC link to the PCM

Quit and return to the initial action bar

Repeat the process or exit the option

Access the UICP option

The first screen is divided into three segments with no default data. The top portion of the screen is for search criteria elements. Refer to Figure 2-23. UIC/PCM Maintenance Screen, page 2-86. The middle portion is blank. The bottom portion contains the action bar for use throughout this option and differs as selections are made and data is entered.

The action bar initially displays a choice to (Q)uit the menu option, (D)irect to assign units to a PCM if the PCM is known and the units to assign to the PCM are known as well, or (C)hange Search Criteria to institute a search if the PCMs are unknown.

```
                              UIC/PCM MAINTENANCE

      PCM:                                    Location:
 Specialty:                               Agreement Type:




Select (C)hange Search Criteria, (D)irect, or (Q)uit: C//
```

Figure 2-23. UIC/PCM Maintenance Screen

Enter the search criteria

Press <Return> to accept the default (C)hange Search Criteria action.

The system displays selectable search criteria in the middle Select Window. Refer to Figure 2-24. UIC/PCM Maintenance Screen with Criteria Selections, page 2-87.

```
                              UIC/PCM MAINTENANCE

      PCM:                                    Location:
 Specialty:                               Agreement Type:
-------------------------------------------------------------

   Agreement Type
   Specialty
   Location
   Default Search Criteria
```

```
──────────────── Specialty and Location are Required ────────────────
Use SELECT key to select SEARCH CRITERIA to be changed
```

Figure 2-24. UIC/PCM Maintenance Screen with Criteria Selections

Use <Select> to determine the search criteria. Specialty and Location are required to institute a search. This screen does not have an action bar.

When you have selected the criteria, a series of prompts ask you to enter the choices selected above. When you enter "Location" you may use either ZIP codes, separated by commas, or ZIP code combinations if combinations were created in the ZIP Code Combinations Enter/Edit (ZIPC) option. Refer to Section 2.1.2.4 ZIP Code Combinations Enter/Edit (ZIPC), page 2-62.

If you select (D)irect search from the initial action bar, you are prompted to enter a specific PCM. Once you enter the PCM, the middle Select Window displays the name and pertinent data of the selected PCM. You may expand the information by pressing <F9> or "select" the PCM by pressing <Select>.

After you select a PCM, you may enter or edit UICs with which to link the PCM. All subsequent screens display as described above in (C)hange Search Criteria.

Select the PCM to link

An additional action, (S)earch, now displays on the action bar as the default:

Select (C)hange Search Criteria, (D)irect, (S)earch or (Q)uit: S//

Press <Return> to accept the (S)earch default.

When the search is completed, all providers designated as PCMs who meet the search criteria display along with certain elements from their profiles:

CS	Credentialing Status (e.g., Board Certified)
Cat	Category (e.g., MD, PA, RN)
Specialty	Family Practice, OB
Agr	Agreement (e.g., MTF, Contract, SUP)
Locat	Location (ZIP Code of their clinic)
Sex	M/F
Disc	Discount (e.g., 90%, MTF)
Avail	MCP Patient Enrollments Slots Open for this PCM.

Use <Select> to choose a PCM or expand any PCM to view more information by positioning the cursor next to the PCM you are interested in and pressing <F9>. Information available is assignment preference and place of care. Refer to Figure 2-25. UIC/PCM Maintenance Screen with POC, page 2-89, and Figure 2-26. UIC/PCM Maintenance Screen with Groups as PCMs, page 2-90.

```
                              UIC/PCM MAINTENANCE

       PCM:                                    Location: DISTRICT OF COLUMBIA
 Specialty: FAMILY PRACTICE/PRIMARY C Agreement Type:
--------------------------------------------------------------------------------
-
   Provider                 CS Cat   Specialty        Agr Locat Sex Disc   Avail
_____________________________________________________

   ARRIBA,GILBERT M         E  MD    FAMILY PRACTICE  MTF 20301  M  MTF
485
   BEALE,SHARON M           B  MD    FAMILY PRACTICE  MTF 20301  F  MTF
485
   CRAWFORD,KYLE M             NPC   PRIMARY CARE NUR MTF 20301  M  MTF
485
   DELL,ALICE M                MD    FAMILY PRACTICE  MTF 20301  F  MTF
485
   EDROZO,FRANK M              NPC   PRIMARY CARE NUR MTF 20301  M  MTF
485
   FIESTA,LUISA M              PA    FAMILY PRACTICE/ MTF 20301  F  MTF
485
   GOTT,JOHN M                 PA    FAMILY PRACTICE/ MTF 20301  M  MTF
485
   FAM MED MTF                       FAMILY PRACTICE/ MTF 20301     MTF
474
+  BAXTER,SHARON M          B  MD    FAMILY PRACTICE  MTF 20301  F  MTF
474

Use SELECT key to select PCM to be assigned
Press F9 key to view Assignment Preferences, Place of Care, or Watch Codes
```

Figure 2-25. UIC/PCM Maintenance Screen with POC

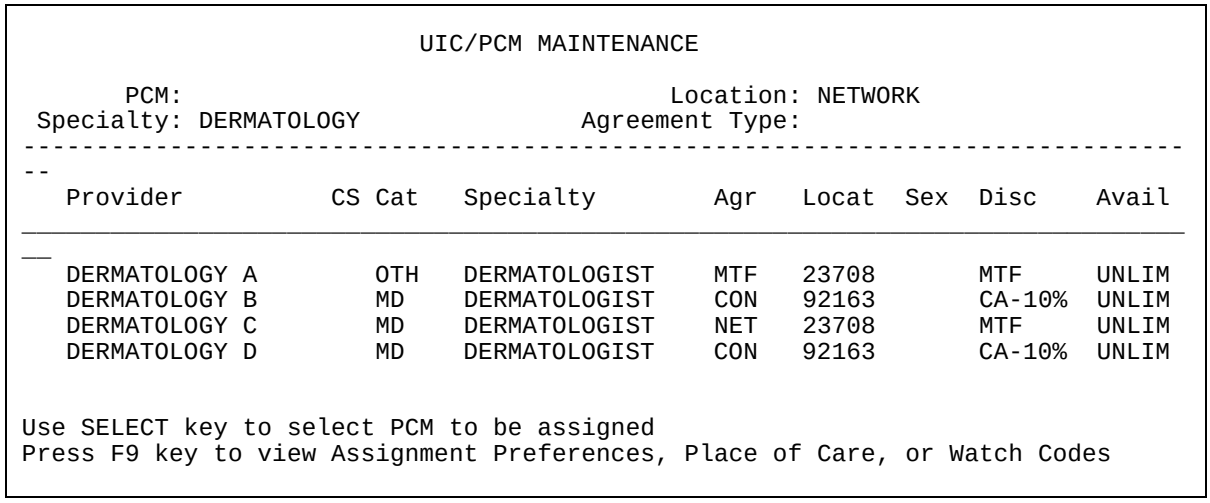


Figure 2-26. UIC/PCM Maintenance Screen with Groups as PCMs

Add a UIC link to the PCM

After you select the PCM, the Watch Code (UIC)/PCM maintenance action bar redisplays with an additional action, (U)ICs, as the default.

Select (C)hange Search Criteria, (D)irect, (S)earch, (U)ICs, or (Q)uit: U//

If you accept the default of (U)ICs, you access a new screen and new action bar. Refer to Figure 2-27. Edit a UIC Screen, page 2-91.

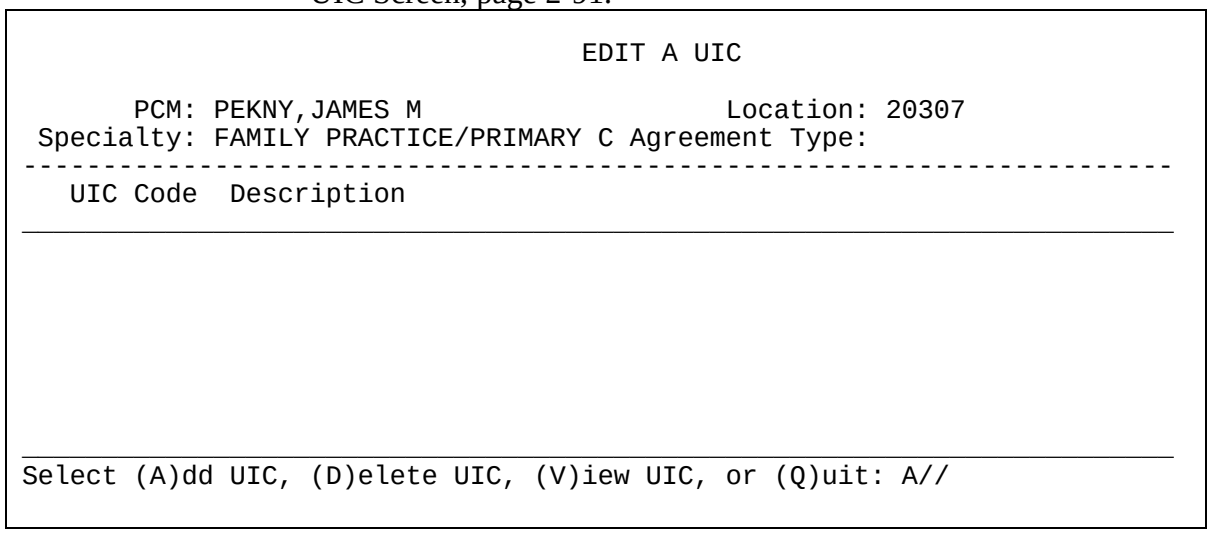


Figure 2-27. Edit a UIC Screen

Select (A)dd UIC, or (Q)uit: A//

If you accept the default of (A)dd UIC, the cursor is positioned in the middle of the screen and allows you to enter a "New UIC" code from the Unit Ship ID file. You may enter the UIC code (e.g., N21225 or a partial name such as "Walter" for Walter Reed).

At the <--*Add a new UIC Code here* prompt, enter the name of the Unit, its Code (UIC) or a partial description. You may also enter a ZIP code and select from the picklist.

Repeat the process to link other units to this PCM.

Verify the UIC code entered.

The cursor is then positioned one line down and is ready to accept another UIC. Refer to Figure 2-28. Edit a UIC Screen with Data, page 2-92.

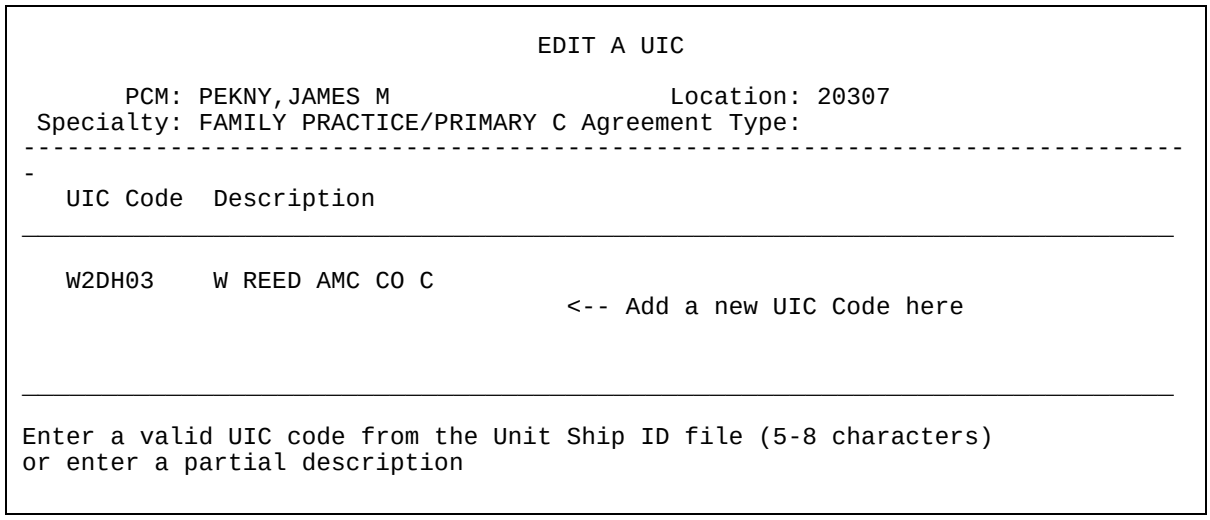


Figure 2-28. Edit a UIC Screen with Data

If you enter a unit that is already assigned to another PCM, you are asked if you want to reassign. If you answer "yes", enrollees in that unit will be assigned to this PCM from this point forward. **Note:** Reassigning the PCM WILL NOT reassign any curently assigned patients to the new PCM. When you have completed entering UICs, a new action bar displays.

Select (A)dd UIC, (D)elete UIC, (V)iew UIC, or (Q)uit: Q//

The first three choices above position the cursor in the middle Select Window. The actions are as follows:

– (V)iew UIC - Allows you to display PCM UICs with no data changes permitted.

– (D)elete UIC - Allows you to "select" a UIC to unlink from this PCM. After selection you are asked "Delete W2DH03 No//". You must change the defaulted "No" to "Yes".

– (A)dd UIC - Allows you to link additional units to this PCM.

– (Q)uit - Allows you to exit the Edit a UIC screen.

Quit and return to the initial action bar

Repeat the process or exit the option

- **Functionality Interaction**

Any patient registration through any functionality may affect this menu option. If patients are registered with units

that do not match entries in the Unit Ship ID file by changing the default in Mini Registration from "*Accept Unit as is? No//*" to "YES," the link will not be effective. You need to manually enter a PCM during a TRICARE enrollment.
This option does not link incorrect UICs with a PCM.

- **Troubleshooting**

Problem – CHCS will not accept a UIC.
Solution – Review the Unit Ship ID file to determine if the unit is correct.
Problem – A unit is not found in the CHCS UIC file.
Solution – Ask the DBA to add entries to this file if necessary.
Problem – Cannot assign active-duty beneficiaries.
Solution: – Assign the CPZ PCM AGR LOCK security key.
The Unit Ship ID file is very large and is maintained by DOD. By the time it is input into CHCS, the data may not be totally correct. Units are constantly moving, activated, or deactivated.

2.1.2.10 Reactivate MCP Enrollment (RACT)

Menu Path: PAS System Menu → M → FMCP → FTAB → RACT

- **Security Keys**

CPZ CCP
CPZ FILE
CPZ PARAMETERS

- **Required Fields**

None

- **Application Description**

The Reactivate MCP Enrollment (RACT) option allows you to reactivate the Enrollment Enter/Edit (EENR) option and other MCP options and actions for the creation and modification of enrollments after they have been disabled by an aborted batch process. These functions are temporarily disabled while a batch disenrollment process submitted by the MCP Parameters Profile Enter/Edit option is in progress. If the process is aborted, then they are disabled indefinitely unless reactivated by this option. They must be reactivated before the batch disenrollment can be resubmitted.
The MCP functions affected by this option are the Enrollment Processing Menu, the Batch PCM

Reassignment Menu, and the following Demographics Display Screen actions: Enrollment, PCM, Case, Family Enrollment, and Disenrollment.
This is not part of file/table for TRICARE. It is a maintenance function.

- **Business Rules**

– If a batch enrollment is aborted while in the enrollment process, the RACT option allows you to restart the process.

- **Other Important Considerations**

This option will probably be used infrequently. The security key should be assigned only to certain individuals who also have access to the MCP Parameters file.

- **Data Entry Process**

Reactivate the Batch Enrollment option

Access the RACT option

Complete the Reactivate the Enrollment Option screen

Exit the option

Access the RACT option
Complete the Reactivate the Enrollment Option screen
After you access this option, a message displays the actions you must take to reactivate the batch enrollment process. Refer to Figure 2-29. Reactivate the Enrollment Option, page 2-95.

```
REACTIVATE THE ENROLLMENT OPTION


This option will reactivate the ENROLLMENT Option if the batch
disenrollment
process is aborted and the enrollment mode is still in the original mode.

To restart the batch disenrollment first reactivate the enrollment option
and then restart the change of enrollment mode in MCP parameters file.


Are you sure you want to reactivate the Enrollment option?
```

Figure 2-29. Reactivate the Enrollment Option

Answer, "*Are you sure you want to reactivate the Enrollment option?*"
If you answer “Yes,” the system responds with "Done!" and allows you to exit the option.
Exit the option

- **Functionality Interactions**

DEERS transactions resume if batch enrollment is restarted.
No other functionality is affected.

- **Troubleshooting**

This option is a troubleshooting tool to restart the batch enrollment process. If it does not work as designed, call the Support Center.

2.1.3 Provider Network File/Table Maintenance Menu (PTAB)

Menu Path: PAS System Menu → FMCP → PTAB

```
   DEPT   Department and Service File Enter/Edit
   PLAC   Place of Care Enter/Edit
   PROV   Provider Enter/Edit
   GROU   Group Enter/Edit
   SPEC   Specialty Type Enter/Edit
   PROF   Professional Category Enter/Edit
   MILI   Military Status Enter/Edit
   WATC   Watch Code Enter/Edit
   AUDI   Audit Trail for Provider Network Menu

Select Provider Network File/Table Maintenance Menu Option:
```

Figure 2-30. Provider Network File/Table Maintenance Menu

- **File Build Sequence**

1. Department and Service File (DEPT)
2. Place of care (PLAC)
3. Provider Enter/Edit (PROV)
4. Group Enter/Edit (GROU)
5. All other files under the PTAB option may be built in any sequence before MCP activation.

2.1.3.1 Department and Service File Enter/Edit (DEPT)

Menu Path: PAS System Menu → M → FMCP → PTAB → DEPT

- **Security Keys**

CPZ CCP
CPZ FILE

- **Required Fields**

Department and Service Name
Code
Dept (if this is a service)
Division (if this is a department)

- **Application Description**

This option allows you enter/edit department and service data in the Department and Service file. A department is the top level of a two-level hierarchy, and a service is the

lower level. All places of care (clinics) must be in the Hospital Location file and must be connected to a department and service. No data should be entered by TRICARE for MTF locations. This option should be used only for civilian places of care and only to create the MCP department and MCP service.

- **Business Rules**

– Build the civilian clinics (places of care) in the Hospital Location file as a non-MTF, non-count location.

– Build the TRICARE/MCP department and TRICARE/MCP service prior to building civilian clinics.

- **Other Important Considerations**

TRICARE non-MTF places of care (civilian offices) must be entered in the Hospital Location file and connected to a department and service. One generic department and one generic service must be built, if not done so already, to establish pointer relationships in the software. The TRICARE/MCP department and service should be established for the civilian places of care.

Because the Department and Service file is a critical file, access to this option should be locked with a site-specific security key. If the TRICARE/MCP department and service have already been built, you should not need access to this file.

MTF clinics should already be built through PAS/common files. If new MTF clinics must be established or a new MTF department and service established, they should be built through common files.

Any new TRICARE/MCP department and service built through this option should be consistent with MTF naming conventions.

- **Data Entry Process**

Enter a new department and/or service

Access the DEPT option

Enter the department name

Complete the DOD Dept and SVC Edit screen

File the data

Repeat the process to enter a service

File the data

Enter another department or service name or exit the option

Access the DEPT option

Enter the department name

Enter the name of the department and verify that you are entering a new department.

Limit the name to 28 characters. The department should be built first (e.g., TRICARE DEPARTMENT).

When you enter the department name, the system displays the DOD Dept and SVC Edit screen. Refer to Figure 2-31. DOD Dept and SVC Edit Screen, page 2-99.

Complete the DOD Dept and SVC Edit screen

```
DEPARTMENT AND SERVICE: TRICARE DEPARTMENT                DOD DEPT AND SVC EDIT

 NAME: TRICARE DEPARTMENT

 CODE:

 DEPT NAME:

 ABBREVIATION:

 Select DIVISION:



 INACTIVE FLAG:



Ask for Help = HELP     Screen Exit = F10     File/Exit = DO          INSERT OFF
```

Figure 2-31. DOD Dept and SVC Edit Screen

1. Name

Defaults to the name entered at the previous prompt.

2. Code

Required field that specifies whether this entry is a service or a department. The department must be built before the service since the service must point to an existing department. The choices in this field are:

S	SERVICE
D	DEPARTMENT
DIV	DIVISION

You may only enter "S" or "D." DIV can no longer be used in CHCS.

3. Dept Name

Leave blank if the entry being built is a department. If the entry is a service, the name of the department that this service points to should be entered.

4. Abbreviation

Optional field that may be used as a lookup code.

5. Division

Required field for departments, but not for services. This field should contain the name of the medical center division that uses this department or service. For the TRICARE/MCP department/service, this should contain the division designated the MCP division.

6. Inactive Flag

Normally used only if this department/service is inactivated. In that case, the entry should be 1 = Inactive. If this field is left blank, the system assumes this department/service is Active.

File the data

Repeat the process to enter a service

All fields are essentially the same except for the following:

1. Dept Name

The name of the department this service points to for workload credit.

2. Division

A service should not have a division entered in this field. This field is for use by departments only.

File the data

Enter another department or service name or exit the option

- **Functionality Interactions**

This file is a common file affecting all functionalities of CHCS. TRICARE (managed care) should contact the DBA for guidance or ask the DBA to make the appropriate entries. If no guidance is forthcoming, managed care only needs an MCP department and one MCP service for the civilian places of care (clinics). All MTF clinics/places of care are usually already built.

Because it is critical to CHCS, this option should be locked with a site-specific security key after the necessary initial MCP entries have been made.

- **Troubleshooting**

Problem – Department and service are built incorrectly.
Solution – Notify DBA.
Problem – The workload count is inaccurate.
Solution – Ensure the MCP department/service is attached to the MCP division.
Problem – MEPRS workload is inaccurate.
Solution – Review this file to ensure it is built correctly; review the place of care profile for the civilian offices to ensure they are built as O NON-MTF clinic, associated with an FC** MEPRS code, and built as a noncount clinic. Print the Provider Group Report to verify this data. Refer to Section 2.2.4.1.2, **Provider Group Report**, page 2-246.

2.1.3.2 Place Of Care Enter/Edit (PLAC)

Menu Path: PAS System Menu → M → FMCP → PTAB → PLAC

- **Security Keys**

CPZ CCP
CPZ FILE
FileMan Code S to add new civilian places of care

- **Required Fields**

If entering a new place of care:

MCP Place of Care
Hospital Location Abbreviation
Hospital Location Type
Hospital Location Division
Facility
Service
MEPRS Code
Street Address
ZIP
Type of Facility
Enrollee Lockout
Type of Care (if Enrollee Lockout is "Yes")
Clinic Type
Roster Production
Prepare Reminder Notice
Activation Status
If entering existing PAS clinic:
MCP Place of Care
Any of the fields above where no data is entered.

- **Application Description**

This option allows you to create a new MCP place of care (clinic) or edit and view the record of an existing MCP place of care. You may also access the Clinic Profile Edit option and update the PAS profile. This option allows you to populate the Hospital Location file and the MCP Place of Care file, that points to the Hospital Location file. Existing PAS locations need to be accessed through this option (PLAC) to review and complete additional fields specific to MCP. This option also allows you to inactivate/reactivate a place of care in ALL provider groups.

- **Business Rules**

– You must enter/access a clinic through this option to populate the MCP place of care profile.
– If hospital locations already exist in the system (PAS profile data complete), enter only MCP place of care data.
– If the PAS profile already exists, do not edit any existing data through this menu option. Edit only MCP place of care information here.
– Limit the Hospital Location Name field to 15 characters to avoid truncation. If the name must be edited for MTF PAS clinics to comply with this rule, PAS should edit it through its profile option.

– MTF PAS clinics (hospital locations) must have the Location Type field set to Clinic or Same Day Surgery. Civilian places of care must have this field set to MCP Non–MTF.
– Set up workload for MTF PAS clinics to be counted. Civilian places of care should be set up as a Non-Count place of care with an F MEPRS code because they are not part of the MTF.
– While building a place of care or accessing an MTF clinic through this option, you MUST press <Return> to advance through all fields the first time to establish MCP pointer relationships. DO NOT use <Do>, <F10> then FILE, or <Next> because pointer relationships may not be established in the files. If keystrokes other than <Return> are needed, they will be included in the field description. Once an MCP Place of Care has been built and pointer relationship established, you may use the function keys mentioned above when accessing this file for review or editing.
– Inactivation/Reactivation of providers or places of care occurs immediately on the inactivation/reactivation date.
– CPZMGR mail group members are responsible for resolving discrepancies listed on the Discrepancy Avoidance Report following provider or place of care inactivations.

- **Other Important Considerations**

PAS clinics should be notified whenever the clinics are edited through MCP. Accessing them and advancing through each field to set the pointers is not editing.
When performing the MCP file and table build, TRICARE/MCP should coordinate with PAS for any site-specific PAS guidelines.
Civilian places of care are necessary to build the TRICARE provider network. The MTF can document appointments made with civilian providers if they and their offices are built in MCP. Any civilian provider appointment already made may be entered in CHCS through MCP and displayed as booked on the patient's record if the civilian places of care are built.
Before entering new civilian locations, review existing entries in this file to preclude entering duplicate places of care.

- **Data Entry Process**

<u>Enter a new TRICARE/MCP place of care</u>

Access the PLAC option

Enter the name of the place of care

Complete the DOD Hosp Location Edit screen

Complete the DOD Hosp Location Edit – Continuation screen

Complete the GRP PL1a screen

Complete the GRP PL2a screen

Complete the GRP PL3a screen

Complete the clinic profile

Complete the SD Clinic Profile screen

Complete the SD Clinic Profile – Continuation screen

Complete the SD Clinic Profile – Continuation (Appointment Types) screen

Complete the SD Clinic Profile – Continuation (Appointment Definition) screen

Complete the clinic profile entry

File the data

Enter a new place of care or exit the option

Access the PLAC option

Enter the name of the place of care

This is a direct entry into the Hospital Location file as well as into the MCP Place of Care file. This should be the formal name of this clinic.

Verify that you are entering a new Hospital Location. The following prompts are displayed, one-by-one. Refer to Figure 2-32. Prompt Series for Enter Place of Care page 2-106.

```
ABBREVIATION:
DESCRIPTION:
LOCATION TYPE:
DIVISION:
MEPRS CODE:
```

Figure 2-32. Prompt Series for Enter Place of Care

1. Abbreviation

Required field of 1 to 6 characters.

2. Description

Optional field of 3 to 30 characters to describe the place of care.

3. Location Type

Required field that identifies the classification of this hospital location. All hospital locations in CHCS are classified through this field and interact differently with other functions and options based on this classification. TRICARE/MCP civilian places of care must be entered as "O" MCP NON-MTF. MTF PAS clinics accessed through MCP must have this field set to "C" CLINIC or "S" for Same Day Surgery.

4. Division

For TRICARE/MCP civilian places of care, this field contains the division designated as the MCP division. MTF clinics should continue to use the division they were built in. TRICARE/MCP civilian places of care should be built through the MCP division only. Do not change an existing division for PAS clinics. **The DMIS ID for this division will become the enrollment DMIS ID if an enrollee picks a PCM practicing at this place of care.**

5. MEPRS Code

For MCP civilian places of care, this will be an FC** MEPRS code. MTF clinics should already have an associated MEPRS code. Under no circumstances, should TRICARE edit this field for PAS clinics. You should contact the office at your MTF handling MEPRS for definitive guidance on the correct MEPRS code to use for the civilian non-MTF places of care.

After you enter the MEPRS code, the system displays the DOD Hosp Location Edit Screen. Refer to Figure 2-33. DOD Hospital Location Edit Screen, page 2-107.

Complete the DOD Hosp Location Edit screen

```
HOSPITAL LOCATION: INTERNAL MED CLINIC                    DOD HOSP LOCATION
EDIT
```

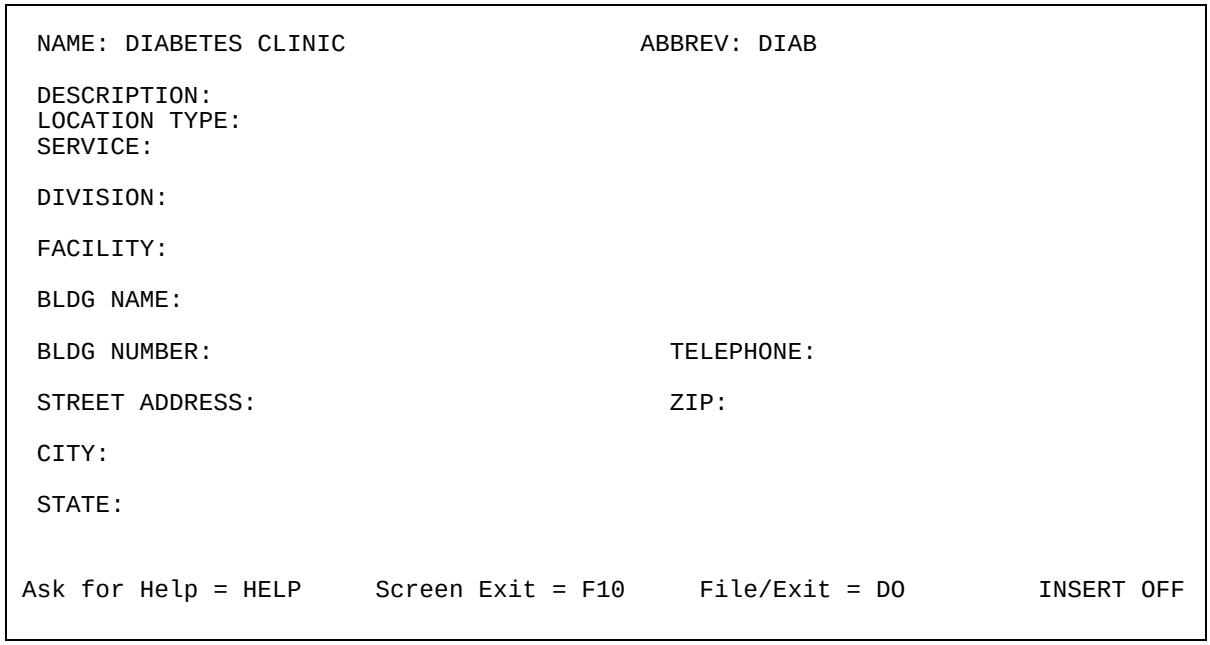


Figure 2-33. DOD Hospital Location Edit Screen

1. Name

Defaults from the previous entries and is not editable. It should be recognizable within the first 15 characters.

2. Abbrev

Defaults from the previous entry and is editable. If the abbreviation is changed here, it also changes in the Hospital Location file.

3. Description

Defaults from the previous entry if entered. This field is optional but does provide further definition and description of the hospital name.

4. Location Type

A critical, system-required field. MCP places of care must be either a location type of clinic or Same Day Surgery for MTF PAS clinics or MCP Non-MTF for civilian places of care. No other location type should be used here by TRICARE. TRICARE should never change this field once it is set.

5. Service

Required field. The clinical area with which this place of care/clinic is associated. The only entry allowed here is from the Department and Service file and must be a Service (e.g., TRICARE SERVICE). Services are linked to departments.

6. Division

Defaults from the previous screen or PCM's place of care Division DMIS ID, and will be the enrollment division for an enrollee assigned to a PCM who practices at this place of care as well as DMIS ID for workload reporting..

7. Facility

Required field. The MTF for this place of care should be your MTF name.

8. The fields Bldg Name, Bldg Number, Telephone, Street Address, and ZIP are not required in this screen but will be required in the place of care profile later. This information should be entered here if available to save time. Overseas locations may enter the closest APO/FPO ZIP code and record the actual city name in the GRPL3a screen as a workaround.

9. The City and State fields default from the ZIP code if entered in the previous field. When this field is completed and you press <Return>, the system continues to the DOD Hosp Location Edit – Continuation screen. Refer to Figure 2-34. DOD Hosp Location Edit – Continuation Screen, page 2-109

Complete the DOD Hosp Location Edit – Continuation screen

```
HOSPITAL LOCATION: INTERNAL MED CLINIC    DOD HOSP LOCATION EDIT - CONTINUATION

 DEFAULT DEVICE:

 SPECIALTY:                                  MEPRS CODE: AAAA

 PROMPT FOR REQUESTING SERVICE:             COST POOL CODE:

 ENROLLEE LOCKOUT:

 TYPE OF CARE:

 Select KEY PERSON:

 Select DUPLICATE CHECKING ORDER TYPE:

INACTIVE FLAG:

Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 2-34. DOD Hosp Location Edit – Continuation Screen

1. Default Device

Optional field. Printer that defaults whenever a lab or X-ray report is printed to this clinic/place of care.

2. Specialty

Optional field. Provider specialty most commonly used in this place of care.

3. MEPRS Code

Required field. All clinic workload is associated with this four-character code. Non-MTF places of care (civilian offices) should use a FC** MEPRS code assigned by your MEPRS office. PAS clinics should already have a code assigned by MEPRS. This code should never be changed without MEPRS office permission.

4. Prompt for Requesting Service

Used as a parameter for booking. If set to "YES," this prompt displays at the time of booking so the MEPRS code of the requesting service may be entered. This is recommended for clinics that do a majority of their work through referrals. If in doubt, you may leave it blank.

5. Cost Pool Code

Required only if a MEPRS code is not used. This is used occasionally when resources are shared. All TRICARE civilian places of care should leave this field blank.

6. Enrollee Lockout

Required field in CHCS Version 4.5. If this field is set to "YES," patient appointment processes in MTF PAS clinics are subject to MCP booking rules and may require an MCP appointment referral before a TRICARE patient can be booked to that PAS clinic or require that enrollees book primary care appointments with their PCM. If set to "NO," no MCP interaction occurs. TRICARE civilian places of care may be set either way since they are not affected by the PAS software booking rules.

7. Type of Care

Also new with CHCS Version 4.5. Not required if the Enrollee Lockout is set to "NO." If Enrollee Lockout is set to "YES," this field must be defined. The choices are:

S = Specialty Clinic
P = Primary Care Clinic
B = Specialty and Primary Care Clinic

If no entry is made, this field defaults to "B" for both at time of installation for all MTF places of care.

8. Select Key Person

Optional field. The name of the main point of contact for this location. This is normally used by lab and X-ray. If filled in, the name should be in the CHCS User file. TRICARE civilian places of care should leave this blank since none of their personnel are CHCS users.

9. Select Duplicate Checking Order Type

Optional field for MTF clinics. This field is used with certain order types in CHCS. For TRICARE purposes, this field may be left blank without affecting any other functionality.

10. Inactive Flag

Used only when the clinic is obsolete. The only entry possible is Inactive. If left blank, CHCS assumes this clinic/place of care is Active.

File this screen.

The system displays the GRP PL1a screen. Refer to Figure 2-35. GRP PL1a Screen, page 2-111.

Complete the GRP PL1a screen

The fields in this screen should default from the DOD Hosp Location Edit screen if entered there.

```
HOSPITAL LOCATION: INTERNAL MED CLINIC                          GRP PL1a

                                PLACE OF CARE

 ========================================================================
```

```
             Name: INTERNAL MED CLINIC
  Location Abbrev: INTER
    Building Name:
  Building Number:
   Street Address: 6885 16TH STREET
              Zip: 20307
             City: WASHINGTON
            State: DISTRICT OF COL
            Phone: 202 271-5851



Ask for Help = HELP     Screen Exit = F10     File/Exit = DO   INSERT OFF
```

Figure 2-35. GRP PL1a

You cannot file this screen without entering a street address and ZIP code.

If all fields have data, press <Return> to advance through all fields. DO NOT use <Do>, <Next Screen>, or <Prev Screen> to move between screens while performing file and table build to ensure MCP place of care pointer relationships are established.

When you press <Return> after entering the phone number, the system displays the GRP PL2a screen. Refer to Figure 2-36. GRP PL2a Screen, page 2-112.

Complete the GRP PL2a screen

```
MCP PLACE OF CARE: INTERNAL MED CLINIC                          GRP PL2a

                                PLACE OF CARE

 ========================================================================

       Type of Facility: MULTISERVICE CLINIC
           Appt Contact: Appointment Clerk
               DMIS ID#: 0037     WALTER REED AMC

-----------------------------Hours of Service-------------------------
 Day of Week             AM                        PM
  MONDAY            0800 -  1200              1201  -  1700
  TUESDAY           0800 -  1200              1201  -  1700
  WEDNESDAY         0800 -  1200              1201  -  1700
  THURSDAY          0800 -  1200              1201  -  1700
+ FRIDAY            0800 -  1200              1201  -  1700



Ask for Help = HELP     Screen Exit = F10     File/Exit = DO   INSERT OFF
```

Figure 2-36. GRP PL2a Screen

1. Type of Facility

Required field, informational only. Most places of care are set up as Multiservice or Single Service. Enter a double question mark (??) to display other choices.

2. Appt Contact

Optional field. The name of the person in the place of care to contact for appointments.

3. DMIS ID #

Required field that defaults from the medical center division being used. This field is not editable from this screen.

4. Hours of Service

Optional field, informational only. The cursor is positioned at the extreme left of the field. To enter a day of the week:

a) Press <Return> and move the cursor one space to the right.

b) Enter the day of the week here.

c) The cursor then moves to the AM field. Enter hours in military time from 0001 to 1200.

d) The PM field requires the times between 1201 and 2400. The days and times entered here should reflect the clinic/ place of care operating hours.

File the Hours of Service.

The system displays the GRP PL3a screen. Refer to Figure 2-37. GRP PL3a Screen, page 2-114.

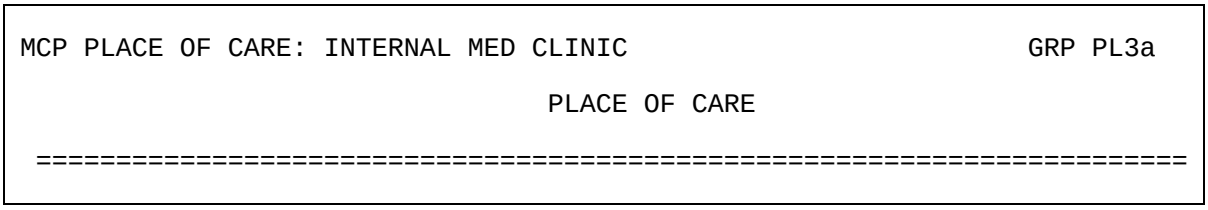
Complete the GRP PL3a screen

The fields Directions to Place of Care and Comments on Place of Care are free-text, informational, optional fields. Information entered here may be printed when:

- Enrolling to TRICARE
- Booking appointments through TRICARE/MCP
- Printing a CAF.

They may also display when expanding the place of care associated with a provider during a provider search in MCP.

These fields give directions to patients or provide them with special information such as handicap accessibility. The person requesting an appointment may not be familiar with the area and may need this information.



```
------------------------Directions to Place of Care--------------------
 Proceed north on 16th Street and exit right on Alaska Avenue.
 Walter Reed Army Medical Center is on the right.



-------------------------Comments on Place of Care---------------------
 Handicapped parking and wheelchair access is available.


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO   INSERT OFF
```

Figure 2-37. GRP PL3a Screen

Directions to place of care.
Comments on place of care.
File the data.

Complete the clinic profile

The system asks *Enter PAS Clinic Profile for this Place Care? Yes//*
Answer "NO," to exit this option.
Answer "YES" if this is a new TRICARE place of care. If new, it does not have a PAS profile and does not display through PAS options such as End-of-Day Processing (EOD)/Editing. You also are not able to book appointments nor define enrollment capacities for individual providers.
After you answer "YES" to the previous prompt, the system prompts you to select (A)ctive, (I)nactive, or (Quit). Press <Return> to accept the default (A)ctive.
If you accept the default, the SD Clinic Profile screen displays. Refer to Figure 2-38. SD Clinic Profile Screen, page 2-115. This also allows you to complete a PAS profile for this clinic so that it is accessible through the PAS options as well as MCP options.

Complete the SD Clinic Profile screen

```
HOSPITAL LOCATION: ACUTE CR MTF                          SD CLINIC PROFILE

                Name: ACUTE CR MTF
        Abbreviation: ACCM
            Facility: WALTER REED AMC WASHINGTON DC
            Division: DIV A - TRAINING HOSPITAL
       Building Name:
     Building Number:
      Street Address: 6885 16TH STREET
                 ZIP: 20307
                City: WASHINGTON
               State: DISTRICT OF COLUMBIA
     Clinic Location:
 Clinic Availability:
           Telephone: 202 271-5851
```

```
    Enrollee Lockout: YES
        Type of Care: BOTH SPECIALTY AND PRIMARY CARE
             Service: PRIMARY CARE SERVICE
          Department: PRIMARY CARE DEPARTMENT
           Specialty:
          MEPRS Code: BGAA


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO   INSERT OFF
```

Figure 2-38. SD Clinic Profile Screen

1. The following fields default from the place of care screens if data is entered:

Name = Clinic/place of care Name
Abbreviation = Unique short code for the clinic. May have a specific letter for naming convention.
Facility = MTF with which this clinic is associated.
Building Name, Building Number, Street Address, ZIP, City, State, Telephone
Enrollee Lockout = YES or NO
Type of Care = P, S, or B if Enrollee Lockout is YES
Service = From the Dept and Service file
Department = From the Dept and Service File
Specialty = Provider specialty
MEPRS Code = From the MEPRS file

2. Clinic Location:

A free-text, informational, optional field. The area of the MTF or building where the clinic is located (e.g., 1st floor/Suite B).

3. Clinic Availability:

A free-text, informational, optional field. The operational hours of that clinic/place of care.

File this screen and continue to the next screen. Refer to Figure 2-39. SD Clinic Profile – Continuation Screen, page 2-116.

Complete the SD Clinic Profile – Continuation screen

```
HOSPITAL LOCATION: ACUTE CR MTF              SD CLINIC PROFILE - CONTINUATION

           Wait List Activated:          Maximum Wait List Days:       day(s)
  Wait List Provider Mandatory:           Wait List Hold Duration:      day(s)
     Auto Wait List Processing:            Schedule Hold Duration:      day(s)
 Prompt for Requesting Service:               Patient Record Pull:      day(s)
                   Clinic Type:             Radiology Record Pull:       day(s)
             Check Holiday File:                 Roster Production:     day(s)
                 Cost Pool Code:          Prepare Reminder Notice:      day(s)
              Activation Status:               Available Schedule:      day(s)
      Clinic Appt Instructions:
```

```
Ask for Help = HELP     Screen Exit = F10     File/Exit = DO          INSERT
OFF
```

Figure 2-39. SD Clinic Profile – Continuation Screen

1. Wait List Activated

Activates the Wait List for a clinic if set to 1 for "YES." Non-MTF MCP places of care should set this to "NO" since civilian offices do not maintain wait lists or have access to CHCS. TRICARE/MCP should not change this setting for MTF clinics. If set to "NO," the Wait List parameters are bypassed (items 2 through 5).

2. Maximum Wait List Days

Not accessed by non-MTF clinics.

3. Wait List Provider

Required field.. If set to "YES," when entering a Wait List request, the user must enter the names of the provider for whom the Wait List request is intended. TRICARE should not change this setting for MTF clinics.

4. Wait List Hold Duration

Designates how long a patient will remain on the Wait List. Set this field to zero (0) for non-MTF clinics since civilian clinics do not have access to CHCS. TRICARE should not change this setting for MTF clinics.

5. Auto Wait List Processing

If set to "YES," Wait Lists are automatically processed if schedules were created for Wait List processing only (slot status set to "wait"). TRICARE should not change this setting for MTF clinics.

6. Schedule Hold Duration

The number of days before the appointment Frozen slots are automatically changed to Open. Non-MTF locations should set this to zero (0) since they have no schedules in CHCS.

7. Prompt for Requesting Service

Displays a prompt asking for the requesting service when booking appointments if set to "YES." You can enter a MEPRS code that can report workload. An ad hoc report could capture this information if the data was required for non-MTF places of care. Enter "YES" or leave the field blank.

8. Patient Record Pull

Number of days in advance of an appointment a patient's record should be pulled. Unless the MTF allows patient records to be sent to civilian offices, set this field to zero (0) for TRICARE places of care.

9. Clinic Type

Controls whether workload from this clinic is counted., Set this field to zero (0) for Non-Count since civilian workload is not reportable under MEPRS. PAS clinics set this field to Count.

10. Radiology Record Pull

Number of days in advance of an appointment a patient's record should be pulled. Set this field to zero (0) for TRICARE places of care.

11. Check Holiday File

Allows CHCS to skip holidays when schedules are built and appointment slots created. Non-MTF locations should

set this to "NO" since CHCS does not maintain civilian schedules.

12. Roster Production

Required field. Indicates the number of days before an appointment that the system prints appointment rosters. Set this field to “NO” for Non-MTF locations since CHCS does not maintain civilian schedules.

13. Cost Pool Code

If a MEPRS code was entered at the MEPRS Code prompt on the DOD Hosp Location Edit - Continuation screen, the Cost Pool Code field in not accessible here. For all TRICARE civilian places of care, this field remains blank.

14. Prepare Reminder Notice

Required field. Type in a whole number between 4 to 30, to identify the number of days prior to a booked appointment a reminder notice should be generated.

15. Activation Status

Controls whether a place of care is an Active Clinic in CHCS. This should be set to 1 - Activated for all clinics and TRICARE places of care that are active.

16. Available Schedule

The minimal number of days a schedule is available in CHCS. This field is not applicable to non-MTF clinics and may be bypassed by pressing <Return>.

17. Clinic Appt Instructions

Generic brief patient instruction for this clinic. This field is not applicable to non-MTF clinics and may be bypassed by pressing <Return>.

The system displays the next screen. Refer to Figure 2-40. SD Clinic Profile - Continuation Screen, page 2-120.

Complete the SD Clinic Profile – Continuation (Appointment Types) screen

```
HOSPITAL LOCATION: ACUTE CR MTF        SD CLINIC PROFILE - CONTINUATION

 Select APPOINTMENT TYPE:




Ask for Help = HELP     Screen Exit = F10     File/Exit = DO
```

Figure 2-40. SD Clinic Profile - Continuation Screen

At the *Select APPOINTMENT TYPE* prompt, enter the appointment type you desire for this clinic. MTF clinics

may already have this information defaulted and you may bypass this screen entirely by pressing the down-arrow key until the *File* prompt displays. Exit by pressing <Return>.
If a valid appointment type such as NEW is entered, the system displays a small window with the *APPOINTMENT TYPE DURATION* prompt.
You may specify the length of this appointment type in minutes. CHCS will create slots of that length when booking to this place of care.
After you enter appointment duration, the system displays the last SD Clinic Profile screen. Refer to Figure 2-41. SD Clinic Profile – Continuation, page 2-121.

Complete the SD Clinic Profile – Continuation (Appointment Definition) screen

```
APPOINTMENT TYPE: NEW                    SD CLINIC PROFILE - CONTINUATION

                Duration:                                  Status:
           Workload Type:                      Referral Required:
     Pull Patient Record:                   Pull Radiology Record:
 Produce Encounter Forms:                    Send Reminder Notice:
    Total # of Overbooks:             Max # of Overbooks Per Slot:
            Instructions:
 Select BOOKING AUTHORITY:



 Select APPT CHANGE AUTHORITY:


 Select OVERBOOK AUTHORITY:



Ask for Help = HELP     Screen Exit = F10     File/Exit = DO   INSERT OFF
```

Figure 2-41. SD Clinic Profile – Continuation

1. Duration

Defaults from the previous screen and may be edited here.

2. Status

Displays the word Active but the appointment type does not become active until you advance through the field and highlight it.

3. Workload Type

Defaults to Count, but must be changed to Non-Count for civilian places of care since non-MTF places of care are not included in the MTF workload report.

4. Referral Required

Optional. If set to "YES," this field becomes optional during booking. If set to "NO," the field is not accessible.

5. Pull Patient Record

Requires data. If set to "YES," the patient's record is required for this appointment type and is pulled "X" number of days prior to appointment. Most non-MTF locations are set to "NO" unless MTF policy requires otherwise.

6. Pull Radiology Record

Requires data. If set to "YES," the patient's record is pulled "X" number of days prior to appointment. Most non-MTF clinic locations are set to "NO" unless MTF policy requires otherwise.

7. Send Reminder Notice

If set to "YES," an appointment reminder mailer is generated and mailed.

8. Produce Encounter Forms

Allows you to produce a single SF600 form if set to "YES." Encounter Form is batched for all pending appointments with this appointment type. Set to “NO” since non-MTF facilities do not have access to CHCS.

The remaining fields may be left blank for TRICARE civilian places of care since the MTF does not have access to non-MTF place of care booking schedules. MTF PAS clinics enter this data through the PAS module. DO NOT make any changes for them.

Complete the clinic profile entry

At the Clinic-to-Provider Appointment Type Transfer screen, answer the prompt, *Transfer newly added appointment type(s) to Provider Profile(s)? No//* If no providers are within the place of care yet, accept the default.

File the data

Enter a new place of care or exit the option

Enter an existing PAS clinic as a MCP place of care

Access the PLAC option

Enter the name of the place of care

Complete all remaining screens:

- **DOD Hosp Location Edit screen**
- **DOD Hosp Location Edit – Continuation screen**
- **GRP PL1a screen**

- **GRP PL2a screen**
- **GRP PL3a screen**
- **Clinic profile**
- **SD Clinic Profile screen**
- **SD Clinic Profile – Continuation screen**
- **SD Clinic Profile – Continuation (Appointment Types) screen**
- **SD Clinic Profile – Continuation (Appointment Definition) screen**
- **Clinic profile entry**

File the data

Enter a new place of care or exit the option

Access the PLAC option
Enter the name of the place of care
Select (E) to access the next screen. ALL PAS clinics must be defined as MCP places of care.
Complete all remaining screens
Press <Return> to advance through all fields and complete data where needed or missing. DO NOT change any data.
File the data
Enter a new place of care or exit the option

- **Functionality Interactions**

This option interacts with PAS file and table. It is imperative that the MCP file and table build process not change any data already entered for the MTF clinics. Any contemplated changes should be made by PAS.
All clinics/MCP places of care require Medical Expense Performance Reporting System (MEPRS) codes to accurately count workload. Non-MTF places of care should use a FC** code requested from your MEPRS office.

- **Troubleshooting**

Be sure all non-MTF places of care are Non-Count clinics and their appointment types are Non-Count as well.
Verify all data for non-MTF clinics so that addresses and phone numbers are correct.
Verify that the "Service" field in the Place of Care Profile contains a service and not a department.

2.1.3.2.1 Place of Care - Inactivate/Reactivate

Inactivate/Reactivate an MCP place of care in all provider groups

Note: Refer to Section 2.2.1.4 , **GNET – Inactivation/Reactivation**, page 2-210, to inactivate/reactivate a place of care for one provider or for one provider group.

Access the PLAC option

Complete the Inactivation/Reactivation of Place of Care

File the data

Generate a Discrepancy Avoidance Report if needed

Enter another place of care or exit the option

Access the PLAC option
The system prompts you to select the MCP place of care you want to enter/edit. Refer to Figure 2-42. MCP Place of Care Enter/Edit (PLAC) Option Initial Prompt, page 2-125.

```
MCP PLACE OF CARE Enter/Edit

Select MCP PLACE OF CARE:
```

Figure 2-42. MCP Place of Care Enter/Edit (PLAC) Option Initial Prompt

Enter the place of care name.
The system displays the initial action bar prompting you to edit the place of care profile, inactivate/reactivate the place of care or quit. Refer to Figure 2-43. PLAC Initial Action Bar, page 2-125.

Complete the Inactivation/Reactivation of the place of care

```
MCP PLACE OF CARE Enter/Edit

Select MCP PLACE OF CARE: NUCLEAR MEDICINE CLINIC
Select (E)dit Profile, (I)nactivate/Reactivate, or (Q)uit: E//
```

Figure 2-43. PLAC Initial Action Bar

Enter I to select the (I)nactivate/Reactivate action.
The system displays the Inactivation/Reactivation of Place of Care screen where you can enter an inactivation or reactivation date and reason for the inactivation/reactivation. Refer to Figure 2-44. Inactivation/Reactivation of Place of Care Screen, page 2-125.

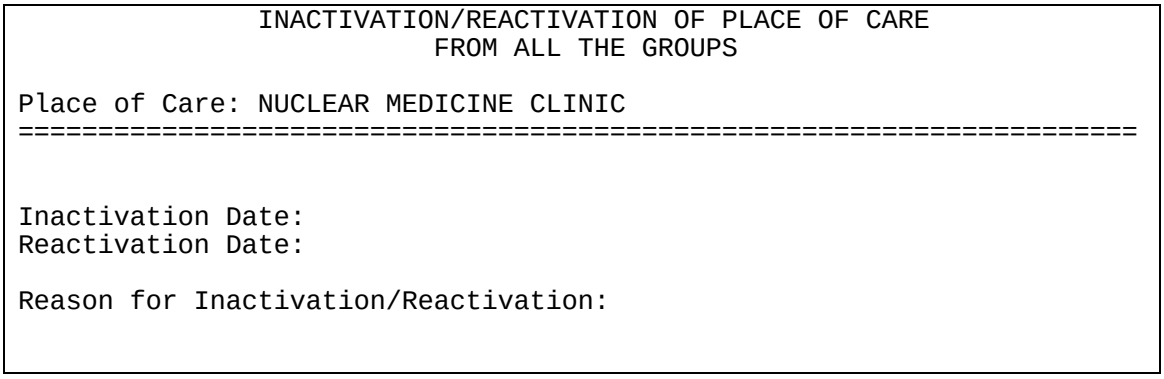


Figure 2-44. Inactivation/Reactivation of Place of Care Screen

Enter the inactivation date.

Enter reason for inactivation.

File the data

Generate a Discrepancy Avoidance Report if needed

The system checks for any discrepancies linked to the inactivation and prompts you to generate a Discrepancy Avoidance Report if any discrepancies are found. Refer to Figure 2-45. Reminder to Run the Discrepancy Avoidance Report, page 2-127.

```
NUCLEAR MEDICINE will be inactivated on 07 Aug 1997 !!

                    DISCREPANCY AVOIDANCE REPORT

,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,

                         This may be a COMPLEX report.
                            Please queue it to print
                   during the night or other non-peak hours.
              Printing it NOW may impact other users on the system.

,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Do you want to proceed with this report? No//
```

Figure 2-45. Reminder to Run the Discrepancy Avoidance Report

The Discrepancy Avoidance Report lists any pending appointments/Wait List requests, PCM assignments, and referral numbers linked to providers at the inactivated place of care. The discrepancies identified must be resolved for the providers in the provider groups linked to the inactivated place of care. Refer to **Figure 2-135. Discrepancy Avoidance Report**, page 2-281.

Queue the report to run during non-peak hours.

You return to the initial *Select MCP PLACE OF CARE* prompt where you can enter another place of care to inactivate/reactivate in all groups or exit the option.

Enter another place of care or exit the option

Press <Return> to exit the option.

Note: You can follow this same procedure to reactivate or inactivate a place of care in all groups.

The system also generates a mail bulletin (refer to Figure 2-46. Inactivated Place of Care Bulletin, page 2-128) to the CPZMGR mail group when the inactivation is to become effective. The bulletin also reminds mail group members to generate the Discrepancy Avoidance Report. Any discrepancy identified must be resolved for the inactivated place of care.

```
Subj: Inactivated Place of Care  Thu, 07 Aug 1997 10:01:41  29 Lines
From: POSTMASTER (Sender: REYNOLDS,JOYCE) in 'IN' basket.  **NEW**
,,,,,,,,,,,,,,,,,,,,,,,,,,,Expires: 11 Aug 1997,,,,,,,,,,,,,,,,,,,,,,,
The following Place of Care will be inactivated:

         Place of Care: NUCLEAR MEDICINE
     Inactivation date: 07 Aug 1997
     Reactivation date:

Reason for Inactivation/Reactivation:
     Cardiology services moved to main clinic

------------------------------------------------------------------------
  Groups
     Providers
------------------------------------------------------------------------
  HIGH TECH MEDICAL GROUP
     CRAWFORD,CATHERINE
     DUNHAM,GEORGE
  GREENE MEDICAL GROUP
     HARRISON,RICHARD
     JAMISON,LILLIAN
.....OAKLEY,MARGARET

REMINDER:
Print the Discrepancy Avoidance Report to check for any discrepancies.

Select MESSAGE Action: IGNORE (in IN basket)//
```

Figure 2-46. Inactivated Place of Care Bulletin

2.1.3.3 Provider Enter/Edit (PROV)

Menu Path: PAS System Menu → M → FMCP → PTAB → PROV

- **Security Keys**

CPZ CCP
CPZ FILE
FileMan code # or P

- **Required Fields**

Provider Name
Provider Flag
Provider Location
Provider Class
Provider ID
Rank
Specialty
Professional Category

- **Application Description**

This option allows you to enter a new MCP provider and associated profile data to a clinic/place of care, or to edit or view records of existing individual providers assigned to a clinic/place of care. The data includes military status, specialties, professional category, and languages. Additionally, you can use this option to inactivate or reactivate the provider at the clinic level. After inactivating data, the system allows you to generate and print the Discrepancy Avoidance Report if discrepancies exist.

- **Business Rules**

– Enter MTF providers through the User file by DBA, Facility Quality Assurance (FQA), or someone designated to maintain this file. Do not use the MCP Provider (PROV) option to enter new MTF providers because of credentialing issues.
– Enter non-MTF providers (civilian TRICARE providers) through this option if no MTF conflict arises.
– TRICARE civilian providers must be in the MCP provider file to enable them to be associated with a civilian place of care and an MCP group. This allows booking to them through the TRICARE/MCP booking options.
– Establish MCP profiles for all providers through this option to set file pointer relationships. Access all providers, MTF and civilian, through this option to enter them into the MCP Provider file.
– Inactivation/Reactivation of providers or places of care occurs immediately on the inactivation/reactivation date.
– CPZMGR mail group members are responsible for resolving discrepancies listed on the Discrepancy Avoidance Report following provider or place of care inactivations.

- **Other Important Considerations**

Personnel with access to this option may enter new providers and update any existing providers in CHCS. They may affect provider file data adversely if changes are made incorrectly.
For software purposes, assign civilian providers only specialties in the 900-numbered series to avoid creating a Standard Inpatient Data Record (SIDR) number (used for inpatient reporting).
Enter all civilian providers who are members of the network as well as those non-network providers who may be seen by DOD beneficiaries into CHCS.
Do not enter duplicate providers in CHCS. Verify with DBA that the provider you are entering has not previously been entered.

- **Data Entry Process**

Enter a new provider into CHCS and MCP

Access the PROV option

Enter the provider name

Complete the DOD Add Provider screen

Complete the IND PROF1a screen

Complete the IND PROF3a screen

File the data

Enter another provider or exit the option

Access the PROV option

Enter the provider name

Enter the name of the new provider and verify that you are entering a new provider.
If the provider was previously entered into CHCS, the *(E)dit the profile, (I)nactivate/ Reactivate or (Q)uit* prompt displays. If you select (E)dit, the IND PROF1a screen displays. Refer to Figure 2-47. DOD Add Provider Screen, page 2-131.

Complete the DOD Add Provider screen

```
PROVIDER: NEWCOMB,JOHN                                  DOD ADD PROVIDER

 Provider Flag:

 Provider Specialty(s):
```

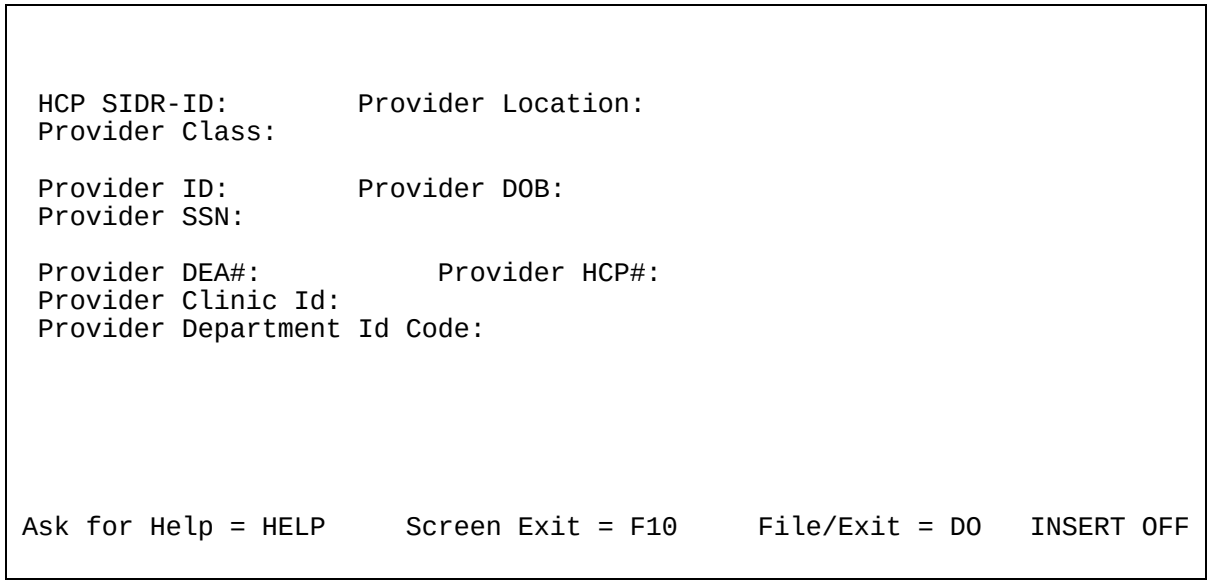


Figure 2-47. DOD Add Provider Screen

1. Provider Flag

Required field. Designates whether the person entered is a provider for order entry. The choices are:

0	NOT A PROVIDER
1	PROVIDER
C	MCP GROUP

If set to "1," Provider, this name displays on picklists of authorized providers. Set this field to "1" for civilian providers entered for TRICARE purposes.

Providers with a value set to zero (0), Not a Provider, may enter orders on behalf of a doctor but do not display on an authorizing HCP picklist. Do not use zero (0) for TRICARE providers.

The choice "C" MCP Group cannot be used.

2. Provider Specialty

Not a required field, but provider specialties should be entered for all providers. The MCP software searches for appointments by provider specialty as one criteria. All specialties in CHCS are identified by a three-digit number. External providers should use a specialty in the 900 series if they never see inpatients at the MTF. This prevents them from being assigned a SIDR number or appearing on the SIDR report. If a 900 series is used, the system bypasses the next field and moves to Provider Location.

3. HCP SIDR-ID

Used for inpatient reporting. This is not used by TRICARE and should not have data for civilian providers who do not

have provider privileges at the MTF. Defaults from the specialty entered and is bypassed if a 900-series specialty is used.

4. Provider Location

Required field. This is another critical field that points to the Hospital Location file (clinics and places of care). This should be the clinic/place of care where this provider is normally assigned.

For MTF providers, this is the outpatient clinic which reports their workload based on the clinic MEPRS code.

For TRICARE civilian providers, this is their office/place of care.

You may enter the clinic/place of care name, the clinic MEPRS code (FC** for civilian places of care), or CHAMPUS Support for civilian places of care. This field provides a critical link between the provider and a clinic/place of care.

5. Provider Class

Required field that should be entered with Outside Provider for TRICARE providers. When the class, Outside Provider, is used, CHCS requires an MTF provider's signature for inpatient orders if this doctor's name is used as an authorizing health care provider (HCP).

6. Provider ID

Required field of 2 to 6 characters. This field provides a unique identifying code for the providers. Before entering any data, ascertain the ID naming convention at your MTF. Everyone entering providers into CHCS should use the same convention. A suggested format is the first five letters of the last name and the first initial (e.g., SMITHJ for Jane Smith) or the first four letters and the first two letters of the first name.

If after entering the code the system does not accept the code and displays question marks, that code is probably already used. In that case, enter a derivative of the format.

7. Provider DOB

Optional field. The provider's date of birth. Enter it if known.

8. Provider SSN

Optional field. Most civilian providers are reluctant to disclose their SSN. If entered, it may be used as a lookup and defaults to the MCP profile.

9. Provider DEA#

Optional field. MTF pharmacies generally require this number and physicians are usually willing to supply it to an MTF. The Drug Enforcement Administration (DEA) number may also be used as a provider lookup tool. The entry must be a valid and unique number. If the number provided is not valid per DEA requirements, CHCS will not accept the entry.

10. Provider HCP#

Optional field. May be a state license number or a unique number assigned by your MTF for tracking purposes. This is not necessary for MCP.

11. Provider Clinic ID

Optional field. For TRICARE purposes, this field may be left blank.

12. Provider Department ID Code

Optional field. May be left blank for TRICARE purposes.

File this screen and continue to the next screen. Refer to Figure 2-48. IND PROF1a Screen, page 2-134.

Complete the IND PROF1a screen

```
PROVIDER: NEWCOMB,JOHN                                          IND PROF1a

                        INDIVIDUAL PROVIDER PROFILE

=========================================================================

            SSN#:                           DEA#:
          Gender:                           Rank:
  Military Status: AD
   Signature Line:

 Specialty(s):
  CARDIOLOGIST


                                    HCP SIDR-ID: 014112
 Languages:


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO   INSERT OFF
```

Figure 2-48. IND PROF1a Screen

1. SSN#

Optional field. Defaults if entered previously as a new provider. If not previously entered, it may be entered here.

2. DEA#

Optional field. Defaults if entered previously as a new provider. This number is entered as two uppercase characters followed by seven digits.

3. Gender

Optional field. Gender is required for provider searches. If not previously entered, enter the sex of the provider if known.

4. Rank

Required field. The military rank of the provider. Non-MTF TRICARE civilian providers should be entered here as XCIV (civilian non-service affiliated).

5. Military Status

Defaults from the provider's rank, informational only.

6. Signature Line

Optional field. The signature line prints on the CAF if entered. This should be "Firstname Lastname, MD (e.g., Clark B. Kent, MD).

7. Specialty(s)

Not a-required field; however, this field is necessary for MCP to function properly. MCP uses this field for provider searches. Defaults if previously entered as a new provider. If not previously entered, you may enter a specialty here from the 900-series number to prevent the SIDR number from being created. Multiple specialties may be entered.

8. Languages

Optional; however, this field should be populated if a provider speaks other than English. Language may be used as a criterion for provider searches. If used, the system marks the provider meeting the language criterion during a search with a tilde (~).

Complete the IND PROF3a screen

Refer to Figure 2-49. IND PROF 3a Screen, page 2-136.

```
MCP PROVIDER: NEWCOMB,JOHN                                        IND PROF3a

                        INDIVIDUAL PROVIDER PROFILE

 ========================================================================

                     UPIN#:
                CHAMPUS NBR:
     Professional Category:




Ask for Help = HELP     Screen Exit = F10     File/Exit = DO   INSERT OFF
```

Figure 2-49. IND PROF 3a Screen

1. UPIN#

Optional, free-text field, limited to 3 to 6 characters. This is a unique identifier used for billing Medicare. If Medicare billing by MTF becomes a possibility, this number may be important.

2. CHAMPUS Nbr

Optional, free-text field. This should be the provider ID number used to file claims with CHAMPUS. CHAMPUS assigns this number to participating, authorized providers.

3. Professional Category

Required field. Indicates the level of professional training this provider has received (e.g., Physician (other than surgeon)). Possible entries are contained in the Professional Category file and may be added to if necessary. Enter a double question mark (??) to display a picklist of professional categories from which to choose.

File the data

Enter another provider or exit the option

- **Functionality Interactions**

This option interfaces with all CHCS functionalities. The MCP Provider file is a common file extremely critical to CHCS. MCP must clarify with QA or DBA what parameters they should enter during data entry.

Other functionalities use this file to either process orders during order entry or for appointment booking. In most MTFs, entry into this file is strictly controlled because of its importance to the entire platform.

- **Troubleshooting**

Problem – When adding a new provider, you receive a message that a unique provider ID is already in use by "____". This indicates this provider was DBA-inactivated but is already in CHCS.
Solution – The same message may display at the SSN field for the same reason. In this case, do not continue entry and create duplicate providers. Press <F10> (abort), contact the DBA to have the provider reactivated.
MCP provider searches depend on various criteria. If you are unable to locate a specific provider, review that provider's file to ensure the specialty and place of care are correct. If this data is correct, review the MCP Provider Group file to ensure location (ZIP code for place of care), and agreement data are correct. You should also ensure that the provider specialty for the specified provider is included under the specialty type being used to perform the provider search. The Provider Group Report prints all provider data elements and is useful for verifying correct provider setup.
If you are unable to locate an MTF provider through MCP, review the MCP Provider file to ensure the provider was also entered in the MCP Provider file.

Inactivate/Reactivate an MCP provider in **ALL** provider groups

Note: To inactivate/reactivate an MCP provider in **ONE** provider group, use this Menu path: PAS System Menu → M → PMCP → GNET

Refer to Section 2.2.1 **Group Profile/agreements Enter Edit (GNET)**, page 2-161.

Access the PROV option

Complete the inactivation

File the data

Inactivate/Reactivate another provider or exit the option

Access the PROV option
Menu Path: PAS System Menu → M → FMCP → PTAB → PROV
The PROV option initial prompt displays. Refer to Figure 2-50. PROV Option Initial Prompt, page 2-138.

```
PROVIDER Enter/Edit
```

```
Select PROVIDER:
```

Figure 2-50. PROV Option Initial Prompt

1. Select provider

Enter the provider name. Once you select the appropriate MCP provider, the system displays the Provider Enter/Edit action bar where you can edit the specified provider's profile or inactivate the provider in all provider groups. Refer to Figure 2-51. Provider Enter/Edit Action Bar, page 2-139.

```
PROVIDER Enter/Edit


Select PROVIDER: SMITH,WILLIAM  SMITH,WILLIAM
         OK? YES//   (YES)

Select (E)dit Profile, (I)nactivate/Reactivate, or (Q)uit: E//
```

Figure 2-51. Provider Enter/Edit Action Bar

2. Select (E)dit Profile, (I)nactivate/Reactivate, or (Q)uit: E//

Enter I to access the (I)nactivate/Reactivate action.

The system displays the Provider Inactivation from All Groups screen (refer to Figure 2-52. Provider Inactivation from All Groups Screen, page 2-139) and prompts you to enter the inactivation date, and the reason for the inactivation.

Complete the inactivation

```
                PROVIDER INACTIVATION FROM ALL GROUPS

Provider: SMITH,WILLIAM
=====================================================================

     Inactivation Date:

     Reason:
```

Figure 2-52. Provider Inactivation from All Groups Screen

1. Inactivation Date

You may enter a past date, today's date, or a date in the future. After the record is filed, the inactivation is effective immediately on the date entered as the inactivation date. The specified MCP provider is inactivated in all MCP provider groups in MCP. Users cannot book MCP appointments, enter Wait List requests, or assign patients to the specified provider as their PCM. Also, the provider no longer appears on any provider picklists throughout MCP.

2. Reason

File the data.

The system checks for any discrepancies linked to the inactivation and prompts you to generate a Discrepancy Avoidance Report if any discrepancies are found. Refer to Figure 2-53. Reminder to Run the Discrepancy Avoidance Report, page 2-140.

```
Provider SMITH,WILLIAM will be inactivated on 06 Aug 1997 !!

                          DISCREPANCY AVOIDANCE REPORT

,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,

                          This may be a COMPLEX report.
                             Please queue it to print
                    during the night or other non-peak hours.
               Printing it NOW may impact other users on the system.


,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Do you want to proceed with this report? No//
```

Figure 2-53. Reminder to Run the Discrepancy Avoidance Report

The Discrepancy Avoidance Report lists any pending MCP appointments/wait list requests or PCM assignments linked to the inactivated provider at any place of care in any provider group. Refer to **Figure 2-135. Discrepancy Avoidance Report**, page 2-281.

Queue the report to run during non-peak hours.

Inactivate/Reactivate another provider or exit the option

Enter another provider or press <Return> to exit the option. The system generates a mail bulletin (refer to Figure 2-54. Inactivation/Reactivation Mail Bulletin, page 2-141) to the CPZMGR mail group when the inactivation is to become effective. The bulletin also reminds mail group members to generate the Discrepancy Avoidance Report. Refer to **Figure 2-135. Discrepancy Avoidance Report**, page 2-281. The discrepancies identified must be resolved for the inactivated provider.

```
Subj: Inactivated Provider  Wed, 06 Aug 1997 09:16:34  19 Lines
From: POSTMASTER (Sender: ROBERTS,ANN) (Postmaster) in     'IN'
basket.  **NEW**
,,,,,,,,,,,,,,,,,,,,,,,,Expires: 06 Sep 1997,,,,,,,,,,,,,,,,,,,,,,

  Provider SMITH,WILLIAM will be inactivated on 06 Aug 1997 !!


Reason for Inactivation/Reactivation:
     Dr. Smith has transferred to another region.

  Provider: SMITH,WILLIAM
-------------------------------------------------------------------
  Groups
     Places of Care
-------------------------------------------------------------------
  SUBURBAN MEDICAL GROUP
     UPTOWN MEDICAL CLINIC
 Press return to continue or "^" to escape
REMINDER:
Print the Discrepancy Avoidance Report to check for any discrepancies.


Select MESSAGE Action: IGNORE (in IN basket)//
```

Figure 2-54. Inactivation/Reactivation Mail Bulletin

Note: You may reactivate a provider in all groups through the same menu path: PAS System Menu → M → FMCP → PTAB → PROV. Then:

1. Enter the provider's name at the initial *Select PROVIDER* prompt.
2. Press <Return> to verify that the system has found the correct provider.
3. Delete the inactivation date.
4. Delete the inactivation reason.
5. Exit the option.

2.1.3.4 Group Enter/Edit (GROU)

Menu Path: PAS System Menu → M → FMCP → PTAB → GROU

- **Security Keys**

CPZ CCP
CPZ FILE

- **Required Fields**

Provider Group
Short Group ID
Provider Type

- **Application Description**

This option allows you to edit or create a new provider group. The provider group is used to connect providers, agreement types, places of care (clinics), and payment

information through the GNET option. Once built, the group serves as the anchor for enrollments, booking, referrals, and PCM activities in the MCP module.

- **Business Rules**

– An MCP provider group may be the same and named the same as an MCP place of care, but a place of care does not need to be an MCP group. A place of care may belong to multiple groups and a group may practice at multiple places of care.

– An MCP provider group may be a clinic, a group provider, or an individual provider. A group should not be an inpatient facility per Health Affairs (HA) Policy.

– MCP provider groups may also be used for bookings, especially for civilian groups that may work on a contractual basis. Supplemental care patients may also be referred to MCP provider groups.

– MTF clinics that act as PCMs can be entered into CHCS as MCP provider groups and set up as group providers.

– The MCP place of care may be the same as the group but exists as an MCP place of care and MCP provider group.

– Civilian TRICARE providers who practice individually should be entered as an MCP group.

– An MTF individual provider, not a member of a group, must be set up as an individual MCP provider group whether the provider is a PCM. A provider that is in individual practice must be set up as a group.

- **Other Important Considerations**

You should decide the following local issues before building any groups:

– Will the MCP provider group be a PCM?

– Will all provider group members also be PCMs?

– Will the MCP provider group have only one place of care (clinic) or will it have multiple places of care?

– If the group is a PCM and the provider members are not, ALL provider schedules display.

– If the MCP provider group is a PCM and some but not all group members are PCMs, only schedules for providers designated as PCMs display and you can only set patient capacities for providers designated as PCMs.

– If the group is not a PCM and some group members are PCMs with assigned enrollees, only the assigned PCM schedules display.
If MCP provider groups are PCMs, the UIC/PCM link must be established with the group after it has been designated a PCM if active-duty beneficiaries are to be assigned to that PCM.

- **Data Entry Process**

Access the GROU option

Enter the name of the group

Complete the Group PRO1a screen

File the data

Enter another group or exit the option

Access the GROU option

Enter the name of the group

1. MCP Provider Group

Enter the name of the group (e.g., TRISTAR Med Group) and verify that you are entering a new group. This may be the name of an MTF provider group (Team #1), the name of an MTF clinic (the name of the provider group as well), the clinic (Family Practice), a civilian group/office (TRISTAR Medical Group), or an MTF/civilian individual provider.
The GROUP PR01a screen displays. Refer to Figure 2-55. Group PRO1a Screen, page 2-145.

Complete the Group PRO1a screen

```
Screen(  ) GROUP PRO1a
------------------------------------------------------------------------------
--
MCP PROVIDER GROUP: TRISTAR MED GROUP                                  GROUP
PRO1a

PROVIDER GROUP PROFILE
==============================================================================
=
       Provider Group Name: TRISTAR MED GROUP
            Short Group ID: TMG
       Tax ID#: 95-2345679
CHAMPUS Number: 3567227
 Provider Type: NETWORK PROVIDER GROUP

 Payment Address 1: PO BOX 4567
 Payment Address 2: 123 N MAIN ST
 Payment Zip: 92137
Payment City: SAN DIEGO
```

```
     Payment State: CALIFORNIA
     Payment Phone: (619)535-2345
   Payment Contact: BILLING CLERK

Ask for Help = HELP     Screen Exit = F10    File/Exit = DO
-------------------------------------------------------------
```

Figure 2-55. Group PRO1a Screen

1. Provider Group Name

Verify that the name of the group is correct and does not require additional data entry. The name defaults in this field from the Provider Group prompt.

2. Short Group ID

Required, free-text field between 3 to 20 characters. A short ID based on the group name is recommended (e.g., TRIMGP).

3. Tax ID#

Optional field. If a civilian group has a tax number used for billing purposes, that number may be entered here.

4. CHAMPUS Number

Optional, free-text field. Civilian groups that bill CHAMPUS are given a number by CHAMPUS for claims adjudication. That number may be entered here but is not required.

5. Provider Type

Required field. This field identifies the group's MCP association; whether the group is in the network; whether it is an institution or provider. Most entries will be Network Provider Group or Non-Network Provider Group. Choices are:

NIS	NETWORK INSTITUTION/SERVICE
NGP	NETWORK PROVIDER GROUP
XIS	NON-NETWORK INSTITUTION/SERVICE
XGP	NON-NETWORK PROVIDER GROUP
OIS	ONLY SERVICE INSTITUTION/SERVICE
OGP	ONLY SERVICE PROVIDER GROUP

6. Payment Address 1

Optional, free-text field. Although the field is not required to build the group initially, the address is required when connecting the group with providers and places of care. This is the address of the office where claims or billing issues are to be sent. In the case of an MTF group, this is the address of the MTF or of the clinic.

7. Payment Address 2

A free-text field that may be used if the previous field is insufficient for the address.

8. Payment ZIP

Not a required field in this screen but required when connecting the network. The ZIP code for the outpatient MTF, clinic, or civilian payment office for this group should be entered here.

9. Payment City

Automatically populated when the ZIP code is entered in the previous field.

10. Payment State

Automatically populated when the ZIP code is entered.

11. Payment Phone

Not a required field in this screen but required when connecting the network. This is the number that patients or others should call when contacting the group or clinic.

12. Payment Contact

This field only appears in this screen and is for information only. This field identifies a POC for a external group offices to address claims processing issues.

File the data

Enter another group or exit the option

If you have completed the place of care and provider profiles, you may now begin associating these files through the GNET option. Refer to Section 2.2.1 **Group Profile/agreements Enter Edit (GNET)**, page 2-161.

- **Functionality Interactions**

Data entered through this option sets pointers to other files but does not affect any other CHCS functionality. The MCP provider group serves as an anchor to link the MCP providers and MCP places of care together for enrollments and patient booking through MCP.

Prior to MCP group data entry, the MCP Provider Type (#8567) file must be populated. This file is uneditable through the GROU option. Based on the provider type, specialty type and location, and type of search selected, the provider displayed is the one in the specified specialty whose individual agreements include that patient type.

- **Troubleshooting**

Setting up the MCP Provider Group normally presents few problems. Most problems are associated with identifying the group as a PCM through the GNET option. Refer to Section 2.2.1 **Group Profile/agreements Enter Edit (GNET)**, page 2-161.

2.1.3.5 Specialty Type Enter/Edit (SPEC)

Menu Path: PAS System Menu → M → FMCP →

PTAB → SPEC

- **Security Keys**

CPZ CCP
CPZ FILE

- **Required Fields**

Provider Specialty Type
Code

- **Application Description**

This option allows you to enter a new MCP provider specialty type that groups provider specialties together for provider searches. You may also edit/view existing MCP provider specialty types. Through this option, you may build combinations of provider specialties to include multiple professionals under a particular specialty type. You can also enter or delete provider specialties for the selected specialty type. You cannot inactivate or delete a specialty type.

- **Business Rules**

– Any new MCP specialty type must have at least one entry from the Provider Specialty file to be effective.
– Provider specialty may be deleted from a specialty type file entry.
– Deleting a provider specialty from a specialty type through this option does not delete it from the Provider Specialty file.

- **Other Important Considerations**

This file allows you to group provider specialties under a specialty type.
This file is of particular importance to MCP, since specialty type is used in MCP to conduct provider searches in health care finder. If a provider's specialty is not listed under a specialty type in this file, you cannot find a provider with that provider specialty when you search for appointments.
This file has numerous entries and should be reviewed for completeness.

- **Data Entry Process**

Enter a new provider specialty type

Access the SPEC option

Enter the specialty type

Complete the CP Provider Specialty Type screen

File the data

Enter another specialty type or exit the option

Access the SPEC option

Enter the specialty type

1. Enter the provider specialty type and verify that you are entering a new specialty type. You cannot edit an existing specialty type code, but you can enter a new code.

The system displays the CP Provider Specialty Type screen. Refer to Figure 2-56. CP Provider Specialty Type Screen, page 2-149.

Complete the CP Provider Specialty Type screen

```
MCP PROVIDER SPECIALTY TYPE: CARDIOLOGIST, PEDIATRI CP PROVIDER SPECIALTY
TYPE

 Specialty Type: CARDIOLOGIST, PEDIATRIC

 Code   Description
  043   CARDIOLOGIST, PEDIATRIC


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO   INSERT OFF
```

Figure 2-56. CP Provider Specialty Type Screen

1. Specialty Type

Defaults from the previous entry and is the name of the specialty type.

2. Specialty Code

Requires a code from the Provider Specialty file.

Press <Return> once to advance the cursor one space to the right and enter the three-digit code you desire. This should be a 900-series code if this entry is intended for external civilian providers.

3. Description

Automatically filled from the code entered in the previous field.

Repeat the process at the code prompt until all codes for this specialty are entered.

File the data

Exit to the *Select* prompt.

Enter another specialty type or exit the option

- **Functionality Interactions**

None

- **Troubleshooting**

Problem – Unable to locate a provider based on his provider specialty.

Solution - Review this file to ensure the provider specialty is correctly grouped within the Specialty Type Enter/Edit (SPEC) option. If correct, review other files such as the Provider file and group network to verify the provider specialty is set correctly for a provider. Also check the provider agreement, patient type, and location.

2.1.3.6 Professional Category Enter/Edit (PROF)

Menu Path: PAS System Menu → M → FMCP → PTAB → PROF

- **Security Keys**

CPZ CCP
CPZ FILE

- **Required Fields**

Professional Category
Description

- **Application Description**

The Professional Category Enter/Edit option allows you to enter a new professional category, or to edit the description of an existing provider professional category. The Professional Category Code field can only be edited if you are adding a new professional category during the current session.

- **Business Rules**

– Existing professional categories may not be edited, deleted, or inactivated. You may only add to the exiting file.

- **Other Important Considerations**

Users must be able to distinguish between categories. MCP personnel should review this file to decide if new entries are needed.

- **Data Entry Process**

Enter a new professional category

Access the PROF option

Enter the professional category

Complete the CP Professional Category screen

File the data

Enter another professional category or exit the option

Access the PROF option

Enter the professional category

Enter the professional category and verify that you are entering a new one. The system displays the CP Professional Category screen. Refer to Figure 2-57. CP Professional Category, page 2-152.

Complete the CP Professional Category screen

```
PROFESSIONAL CATEGORY: TA                          CP PROFESSIONAL CATEGORY

 Professional Category Code: TA
                Description


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO   INSERT OFF
```

Figure 2-57. CP Professional Category

1. Professional Category Code

Defaults from the previous entry and may be edited if incorrect.

2. Description

Required field. Enter a 3 to 30 character description of specific professional categories that are assigned to MCP providers. Examples of professional categories are audiologist, dental surgeon, licensed professional nurse, etc.

File the data

When completed, press <Return> and file this entry.

Enter another professional category or exit the option

You may repeat the process for any other new entry you desire.

Once filed, a professional category cannot be deleted.

- **Functionality Interactions**

None

- **Troubleshooting**

No known problems are associated with this file.

2.1.3.7 Military Status Enter/Edit (MILI)

Menu Path: PAS System Menu → M → FMCP → PTAB → MILI

- **Security Keys**

CPZ CCP
CPZ FILE

- **Required Fields**

Code
Description

- **Application Description**

This option allows you to enter a new military status code and description, or to edit the description of an existing military status. Examples of military status are:

AD	ACTIVE DUTY
CI	CIVILIAN
NG	NATIONAL GUARD
RC	RECALLED TO ACTIVE DUTY
RS	RESERVES

- **Business Rules**

– This file is for use in the MCP provider profile. Entries must exist in the Military Status file before they may be used in the provider profile.

- **Other Important Considerations**

This file is used for informational purposes only.

- **Data Entry Process**

Enter a new military status

Access the MILI option

Enter a new military status

Complete the Military Status screen

File the data

Enter another military status or exit the option

Access the MILI option

Enter a new military status

At the *Select MILITARY STATUS* prompt, enter a new military status code or the one you wish to edit (e.g., AD). Verify that you are entering a new military status. Press <Return> to proceed to the Military Status screen. Refer to Figure 2-58. Military Status Screen, page 2-155.

Complete the Military Status screen

```
MILITARY STATUS: AD                                          MILITARY STATUS


                        MILITARY STATUS ENTER/EDIT
 ========================================================================

           Code: AD
    Description:



Ask for Help = HELP     Screen Exit = F10     File/Exit = DO   INSERT OFF
```

Figure 2-58. Military Status Screen

1. Code

Defaults from the previous prompt and may be edited.

2. Description

Required field and should be an expanded description (3 to 60 characters) of the code previously entered.

File the data

Enter another military status or exit the option

- **Functionality Interactions**

This file affects CHCS quality assurance functionality and the common files.

- **Troubleshooting**

None required.

2.1.3.8 Audit Trail for Provider Network Menu (AUDI)

Menu Path: PAS System Menu → M → FMCP → PTAB → AUDI

This menu contains the options which allow you to generate audit trail reports of data changes in group and provider agreements, places of care, provider groups, and providers. Refer to Figure 2-59. Audit Trail for Provider Network Menu, page 2-156.

```
   AGDC  Agreement Data Changes
   LCDC  Place of Care Data Changes
   GPDC  Group Data Changes
   PRDC  Provider Data Changes

   Select Audit Trail for Provider Network Menu Option:
```

Figure 2-59. Audit Trail for Provider Network Menu

Your MTF must have the audit trail turned on for these reports to be generated.

2.1.3.8.1 Agreement Data Changes (AGDC)

Menu Path: PAS System Menu → M → FMCP → PTAB → AUDI → AGDC

- **Contents**

This option allows you to generate a report showing an audit trail of changes in group and provider agreement data. You may specify that One, Multiple, or All agreements be included in the report. For group agreements, you may specify One, Multiple, or All groups to include in the report. For provider agreements, you may specify One, Multiple, or All groups and One, Multiple, or All providers to include in the report.

- **Use/Frequency**

As often as needed. This report is a troubleshooting tool.

- **Report Sample**

Refer to Figure 2-60. Agreement Data Changes Report, page 2-157.

```
WALTER REED AMC                                    21 Jan 2001@1312 Page 1
                Personal Data - Privacy Act of 1974 (PL 93-579)
                       AGREEMENT DATA CHANGES AUDIT TRAIL
                    MULTIPLE AGREEMENTS/MULTIPLE GROUPS/ALL PROVIDERS
                  Data Changes from 01 Jan 1995 to 01 Jan 2001

 Data Elements: 2 Selected                        Agreements:7 Selected
      Provider: ALL                             Data Elements:8 Selected
=========================================================================
Provider Group
  Provider
    Agreement Type                                        Effective Dates
      Data Element
-------------------------------------------------------------------------
TORRES HEALTH CARE GROUP
  DILLINGER,DONALD
   CON-CONTRACT                                  31 Aug 1996 - 30 Aug 1997
     IND STOP DATE:
     Change Date/Time: 14 Oct 1996 @ 1122  User ID: TURNER,STEVEN
       Old: 31 Dec 1996
       New: 29 Aug 1997

     IND OVERALL DISCOUNT PERCENT
     Change Date/Time: 14 Oct 1996 @ 1122  User ID: TURNER,STEVEN
       Old: 12
       New: 10

     IND START DATE
     Change Date/Time: 14 Oct 1996 @ 1122  User ID: TURNER,STEVEN
       Old: 30 Aug 1995
       New: 30 Aug 1995

    NET-CIVILIAN NETWORK PROVIDER            10 Jun 1996 - 10 Jun 1997
      IND STOP DATE
      Change Date/Time: 14 Oct 1996 @ 1122  User ID: TURNER,STEVEN
        Old: 31 Dec 1996
        New: 13 Jun 1997

      IND OVERALL DISCOUNT PERCENT
      Change Date/Time: 14 Oct 1996 @ 1122  User ID: TURNER,STEVEN
        Old: 12
        New: 10
```

Figure 2-60. Agreement Data Changes Report

2.1.3.8.2 Place of Care Data Changes (LCDC)

Menu Path: PAS System Menu → M → FMCP → PTAB → AUDI → LCDC

- **Contents**

This option allows you to print a report showing an audit trail of changes in place of care data. You may specify One, Multiple, or All places of care to include in the report.

- **Use/Frequency**

As often as needed. This report is a troubleshooting tool.

- **Report Sample**

Refer to Figure 2-61. Places of Care Data Changes Report, page 2-158.

```
WALTER REED AMC                                    21 Jun 2001@1315    Page 1
                Personal Data - Privacy Act of 1974 (PL 93-579)
                     PLACE OF CARE DATA CHANGES AUDIT TRAIL
                  Data Changes from 21 Jun 2001 to 21 Jun 2001

Place of Care: All Places of Care selected
Data Elements: 9
================================================================================
Place of Care
  Data Element
--------------------------------------------------------------------------------
ACUTE CR MTF
  DMIS ID
    Change Date/Time: 21 Jun 2001@1057          User ID: SLATER,PAMELA
                  Old: 6015 CMHA FT. MONMOUTH
                  New: 0037 WALTER REED AMC

NEW ACUTE CR MTF
  DMIS ID
    Change Date/Time: 21 Jun 2001@1130          User ID: SLATER,PAMELA
                  Old: 6015 CMHA Ft. MONMOUTH
                  New: 0037 WALTER REED AMC
```

Figure 2-61. Places of Care Data Changes Report

2.1.3.8.3 Group Data Changes (GPDC)

Menu Path: PAS System Menu → M → FMCP → PTAB → AUDI → GPDC

- **Contents**

This option allows you to print a report showing an audit trail of changes in provider group data. You may specify One, Multiple, or All provider groups to include in the report.

- **Use/Frequency**

As often as needed. This report is a troubleshooting tool.

- **Report Sample**

Refer to Figure 2-62. Group Data Changes Report, page 2-159.

```
WALTER REED AMC                                    21 Jun 2001@1319 Page 1
           Personal Data - Privacy Act of 1974 (PL 93-579)
             PROVIDER GROUP NAME CHANGES AUDIT TRAIL
                  Data Changes from 22 Apr 2001 to 21 Jun 2001

Provider Group: UNITED MED GROUP
================================================================================
Change Date/Time: 18 Jun 2001 @ 1310      User ID: TURNER,STEVEN
  Old Name: ACME MED GROUP
  New Name: UNITED MED GROUP
```

Figure 2-62. Group Data Changes Report

2.1.3.8.4 Provider Data Changes (PRDC)

Menu Path: PAS System Menu → M → FMCP → PTAB → AUDI → PRDC

- **Contents**

This option allows you to print a report showing an audit trail of changes in provider data. You may specify One, Multiple, or All providers to include in the report.

- **Use/Frequency**

As often as needed. This report is a troubleshooting tool.

- **Report Sample**

Refer to Figure 2-63. Provider Data Changes Report, page 2-160.

```
WALTER REED AMC                                    21 Jun 2001@1324  page 1
               Personal Data - Privacy Act of 1974 (PL 93-579)

                     PROVIDER DATA CHANGES AUDIT TRAIL
                 Data Changes from 01 Jan 1995 to 01 Jan 2001

     Provider: 333 Selected
Data Elements: 4 Selected
================================================================================
Provider
  Group
    Data Element
--------------------------------------------------------------------------------
ABRAHAM,JOHN
  CARDIOLOGY PNH
    INACTIVATION DATE
      Change Date/Time: 18 Oct 1996@1414    User ID: HANOVER,KAREN
        Old: 19 Oct 1996
        New: 31 Oct 1996
```

```
    INACTIVATION DATE
      Change Date/Time: 18 Oct 1996@1410    User ID: HANOVER,KAREN
        Old: 19 Oct 1996
        New: 31 Oct 1996

ESPINOZA,RUBEN
  SHARP MAIN GROUP
    INACTIVATION DATE
      Change Date/Time: 14 Oct 1996@1359    User ID: ANDERSON,PAULINE
        Old: 12 Oct 1996
        New: 11 Oct 1996

    INACTIVATION DATE
      Change Date/Time: 13 Oct 1996@1522    User ID: ANDERSON,PAULINE
        Old: 11 Oct 1996
        New: 12 Oct 1996
```

Figure 2-63. Provider Data Changes Report

2.2 Provider Network Management Menu (PMCP)

Refer to Figure 2-64. Provider Network Management Menu, page 2-161, and Sections 2.2.1, 2.2.2, 2.2.3, and 2.2.4.

```
   GNET   Group Profile/Agreements Enter/Edit
   INET   Individual Provider Profile/Agreements Enter/Edit
   ONET   Outputs & Network Management Reports Menu
   MNET   Modify Group Agreement Effective Date

Select Provider Network Management Menu Option:
```

Figure 2-64. Provider Network Management Menu

2.2.1 Group Profile/agreements Enter Edit (GNET)

Menu Path: PAS System Menu → M → PMCP → GNET

- **Security Keys**

CPZ CCP
CPZ FILE
CPZ AGREEMENT
CPZ LOWCAP
CPZ NET

- **Application Description**

This option allows you to associate places of care, agreements, and providers with a provider group. It allows you to edit or view the MCP provider group profile for a selected provider group, and to enter, edit, or view associated clinic profiles for the places of care. You may also enter, edit, terminate, and/or renew group agreements. For any agreement, you may enter, edit, and/or delete procedures and specialty exceptions. You may also add or edit PCM enrollment mix data.

You may enter, edit, or view individual provider profiles. For a given provider, you may enter, edit, or delete data for provider agreements. For a given group agreement, you may indicate whether the provider member participates in it, edit the date or discount rate for the provider, enter procedure and specialty exceptions, and add or edit PCM enrollment mix data, PCM assignment limitations, PCM age limitations, and PCM comments. You may also inactivate or reactivate a place of care within the group, a provider within the group, or a provider within a place of care, and print a Discrepancy Avoidance Report.

This option is used to designate the PCMs, whether they are the group, individual, or both.

- **File Sequence Build**

The following files must be built through the Provider Network File/Table Maintenance Menu (PTAB) option prior to accessing

the Group Profile/Agreements Enter/Edit (GNET) option and completing the provider network:
Department/Service
Division
MCP Place of Care
MCP Provider
MCP Provider Group
To complete the group profile/agreements, follow this sequence in the GNET option:
Place(s) of Care profile completed
Group Agreements entered
Enrollment mix set
Providers attached to the group and places of care
Agreements/PCM enrollment mix set.

- **Other Important Considerations**

Before associating the places of care and providers with the groups you need to decide the following issues:
1. Will the MCP provider group be a (group provider) PCM?
2. Will the individual providers in the group be PCMs as well?
3. Will the MCP provider group have only one place of care (clinic) or will it have multiple places of care?
4. If the MCP provider group is a PCM and does not have a schedule and the individual providers in the group are not, ALL provider schedules display.
5. If the MCP provider group is a PCM and does not have a schedule, and some but not all providers in the group are PCMs, only schedules for providers designated as PCMs display.
6. If the MCP provider group is not a PCM and some providers are PCMs with assigned enrollees, only the individual assigned PCM schedules display.
7. If MCP provider groups are PCMs, the UIC/PCM link must be established with the group after it has been designated a PCM if the group treats active duty.

2.2.1.1 GNET – Place of Care Profile Entry

Menu Path: PAS System Menu → M → PMCP → GNET → Select Provider Group

- **Security Keys**

CPZ CCP
CPZ FILE
CPZ AGREEMENT
CPZ LOWCAP
CPZ NET

- **Required Fields**

Provider Group Name

Location Abbreviation
Street Address
ZIP
Phone

- **Application Description**

This phase of GNET connects the place(s) of care profile to a group and allows you to edit the provider group profile and the place of care data.

- **Business Rules**

– At least one place of care must be entered in the provider group profile through this option for the group to be in effect.

– The name of the place of care may be the same as the MCP provider group but will exist in both the MCP Place of Care and MCP Provider Group files.

– A group may have more than one place of care

- **Other Important Considerations**

If a group has more than one place of care, provider members may be assigned to one or more places of care.

- **Data Entry Process**

Complete the provider group profile

Access the GNET option

Enter the name of the provider group you plan to work on

Complete the GRP PRO1 - Provider Group Profile screen

Complete the GRP PL1 - Provider Group Places of Care screen

Complete the GRP PL2 - Provider Group Places of Care screen

Complete the GRP PL3 - Provider Group Places of Care screen

Enter PAS clinic profile information

Complete the SD Clinic Profile screen

Complete the SD Clinic Profile - Continuation screen

Complete the SD Clinic Profile - Continuation (Appointment Types) screen

File the data

Enter another place of care or file and continue to provider agreements

Access the GNET option

Enter the name of the provider group you plan to work on

At the *Select Provider Group* prompt, enter the name of the group you are building. The system then proceeds to the, GRP PRO1 – Provider Group Profile screen. Refer to Figure 2-65. GRP PRO1 - Provider Group Profile Screen, page 2-166.

Complete the GRP PRO1 – Provider Group Profile screen

All information displayed on this screen defaults from the group profile created in the Group Enter/Edit (GROU) option. Refer to Figure 2-65. GRP PRO1 - Provider Group Profile Screen, page 2-166.

```
MCP PROVIDER GROUP: ACUTE CR MTF                                    GRP PRO1

                            PROVIDER GROUP PROFILE

 ========================================================================
          Short Group ID: ACCM
                 Tax ID#:
          CHAMPUS Number:
           Provider Type: NETWORK PROVIDER GROUP
 Activate Group Provider: NO

 Payment Address 1: 6625 16th Street
 Payment Address 2:
       Payment Zip: 20307
      Payment City: WASHINGTON
     Payment State: DISTRICT OF COL
     Payment Phone: 202 427-1201       Payment Contact: Billing Officer

  Places of Care:
```

Figure 2-65. GRP PRO1 - Provider Group Profile Screen

Press <Return> to advance through all fields until you reach the bottom of the screen. Stop at the Places of Care field. This field should be blank.

Note: The Activate Group Provider field will be set at "NO," but can be changed to "YES." If "YES," this field designates whether this provider group will act as a provider throughout MCP and PAS, have patients assigned as their PCM, have referrals assigned through appointment referral processing and PAS appointments booked to them.

Verify that the address and phone number are correct.
Enter missing information if available.
Press the down-arrow key to position the cursor below the Places of Care field.
Enter the name of the place of care (clinic) to associate with this group.

Note: The Places of Care field will initially be blank. Be sure that the place of care you enter is correct. Once entered, the place of care can never be deleted. You can inactivate a place of care from a group at any time, but you can never delete it.

After you enter the place of care name, press <Return>. The system displays the GRP PL1 - Provider Group Places of Care screen. Refer to Figure 2-66. GRP PL1 - Provider Group Places of Care Screen, page 2-167. When the cursor

is positioned below the name of the place of care, the system bypasses this screen.

Complete the GRP PL1 - Provider Group Places of Care screen

Data describing this place of care is entered on this screen and the following continuation screens. Refer to Figure 2-66. GRP PL1 - Provider Group Places of Care Screen, page 2-167.

```
HOSPITAL LOCATION: ACUTE CR MTF                                    GRP PL1

                         PROVIDER GROUP PLACES OF CARE

 Provider Group: ACUTE CR MTF
 ============================================================================

                       Name: ACUTE CR MTF
      Location Abbreviation: ACCM
               Building Name:
             Building Number:
              Street Address: 6885 16TH STREET
                         Zip: 20307
                        City: WASHINGTON
                       State: DISTRICT OF COL
                       Phone: 202 271-5851



Ask for Help = HELP     Screen Exit = F10     File/Exit = DO   INSERT OFF
```

Figure 2-66. GRP PL1 - Provider Group Places of Care Screen

1. Name

Required field that defaults from the place of care name prompt. Edits may only be made through the Place of Care Enter/Edit (PLAC) option. The cursor bypasses this field.

2. Location Abbreviation

Required field. This field can be edited and is associated with the abbreviation given a hospital location in the Hospital Location file. The default is that abbreviation. You may press <Return> to continue. If you edit the location abbreviation here, you also edit the location abbreviation in the Hospital Location file.

3. Building Name

Optional field that can be bypassed. If you have the information available, you should enter the name of the building here.

4. Building Number

Optional field, 1 to 6 characters. This field identifies the building number (if applicable) associated with a hospital location.

5. Street Address

Required field that should default from the entry in the PLAC option. This field can be edited if the address is incorrect.

6. ZIP

Required field that defaults from the ZIP code entered through the PLAC option. This field can be edited if the ZIP code is incorrect.

7. City and State

These fields cannot be edited but may be changed through the ZIP code entry.

8. Phone

Required field. that can be edited. The phone number entered through the PLAC option defaults here. If not entered previously, you must enter it here before the system allows you to file this screen.

Once you file this screen, the system displays the GRP PL2 - Group Places of Care Screen. Figure 2-67. GRP PL2 - Provider Group Places of Care Screen, page 2-169.

Complete the GRP PL2 - Provider Group Places of Care screen

Additional data about the place of care may be entered here, including hours or service.

The place of care and provider group name display at the top, left side of the screen.

```
MCP PLACE OF CARE: ACUTE CR MTF                                    GRP PL2

                        PROVIDER GROUP PLACES OF CARE

 Provider Group: ACUTE CR MTF
 ============================================================================

          Type of Facility: MULTISERVICE CLINIC
         Appt Contact Name: Appointment Clerk
                   DMIS ID: 0037  WALTER REED AMC

 ------------------------------Hours of Service-------------------------
  Day of Week            AM                        PM
  MONDAY            0800 -  1200              1201  -  1700
  TUESDAY           0800 -  1200              1201  -  1700
  WEDNESDAY         0800 -  1200              1201  -  1700
  THURSDAY          0800 -  1200              1201  -  1700
+ FRIDAY            0800 -  1200              1201  -  1700
```

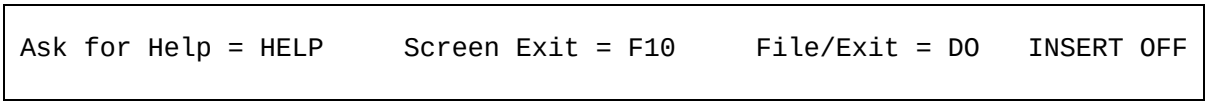


Figure 2-67. GRP PL2 - Provider Group Places of Care Screen

1. Type of Facility

Defaults from the data entered through the PLAC option. This is a required field. and can be edited. Refer to Section 2.1.3.2 **Place Of Care Enter/Edit (PLAC)**, page 2-112.

2. The remaining fields on this screen are optional and are informational only.

This information can be printed through several MCP menu options. The fields display the appointment contact name and hours of operation for that place of care. Press <Return> to advance through all fields to ensure MCP pointers are set. Once completed, file and proceed to the GRP PL3 - Provider Group Places of Care screen. Refer to Figure 2-68. GRP PL3 – Provider Group Places of Care Screen, page 2-170.

Complete the GRP PL3 - Provider Group Places of Care screen

All fields in this screen are free-text and informational for use when printing directions to a place of care for TRICARE patients. All information here defaults from data entered through the PLAC option.

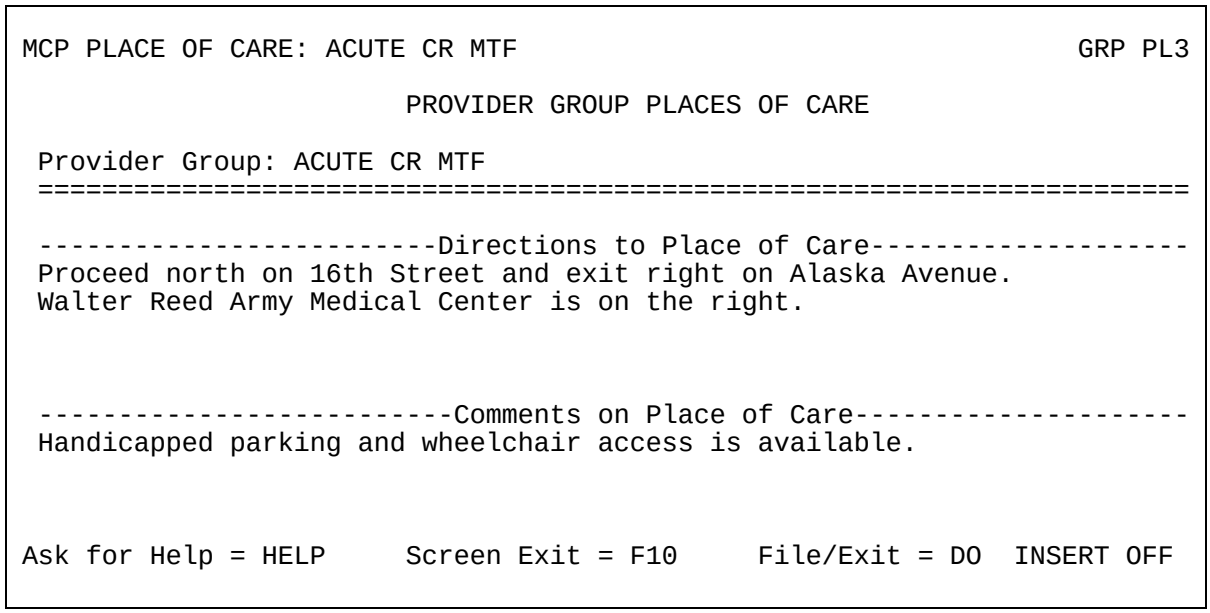


Figure 2-68. GRP PL3 – Provider Group Places of Care Screen

If previously entered, press <Return> to advance through all fields.

When completed and you have reached the bottom of the screen, you are prompted to enter PAS profile information.

Enter PAS clinic profile information

At the *Do you want to enter/edit PAS Clinic Profile information now? Yes//* prompt, press <Return> to accept the "YES" default and continue building the group.

At the *Select (A)ctive, (I)nactive appointment types, or (Q)uit: A//* prompt, press <Return> to access the next screen, SD Clinic Profile. Refer to Figure 2-69. SD Clinic Profile Screen, page 2-171.

Complete the SD Clinic Profile screen

All information displayed in these fields defaults from data entered through the PLAC option. If any data is missing, edit the information through the PLAC option.

```
HOSPITAL LOCATION: ACUTE CR MTF                          SD CLINIC PROFILE

                Name: ACUTE CR MTF
        Abbreviation: ACCM
            Facility: WALTER REED AMC WASHINGTON DC
            Division: DIV A - TRAINING HOSPITAL
       Building Name:
     Building Number:
      Street Address: 6885 16TH STREET
                 ZIP: 20307
                City: WASHINGTON
               State: DISTRICT OF COLUMBIA
     Clinic Location:
 Clinic Availability:
           Telephone: 202 271-5851
    Enrollee Lockout: YES
        Type of Care: BOTH SPECIALTY AND PRIMARY CARE
             Service: PRIMARY CARE SERVICE
          Department: PRIMARY CARE DEPARTMENT
           Specialty:
          MEPRS Code: BGAA


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO  INSERT OFF
```

Figure 2-69. SD Clinic Profile Screen

Press <Return> to advance through all fields until the next screen, SD Clinic Profile - Continuation displays. Refer to Figure 2-70. SD Clinic Profile - Continuation Screen, page 2-172.

Complete the SD Clinic Profile - Continuation screen

The SD Clinic Profile - Continuation screen displays the clinic parameters that affect booking, Wait Lists, schedules and record tracking.

All information should default from data entered through the PLAC option.

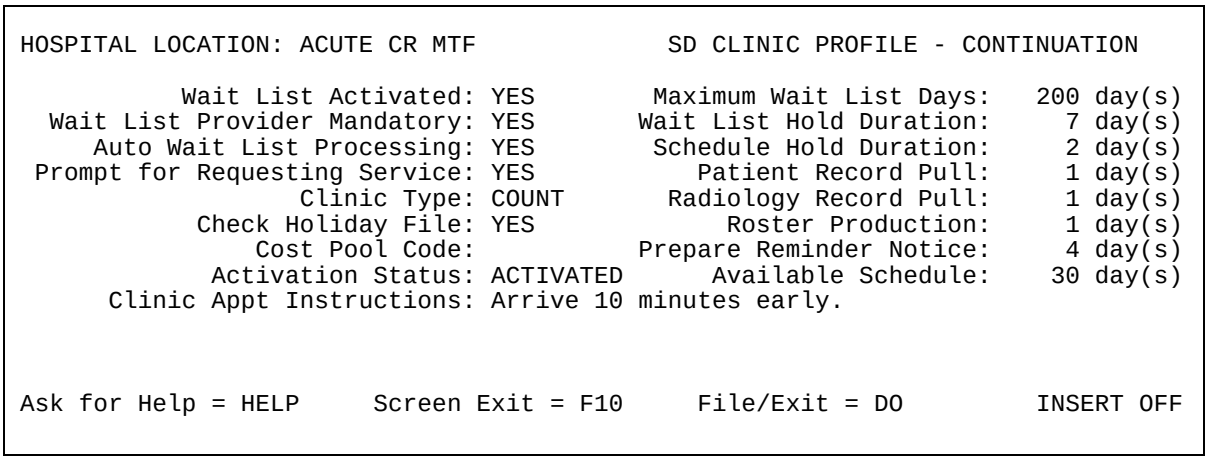


Figure 2-70. SD Clinic Profile - Continuation Screen

Review this screen and ensure that all data is correct. You may also use the PLAC option to edit data.

Press <Return> to advance through all fields. If you cannot advance through a field by pressing <Return>, use the down-arrow key to bypass the field.

After advancing through all fields, the system displays the next screen.

Refer to Figure 2-71. SD Clinic Profile - Continuation (Appointment Types), page 2-173.

Complete the SD Clinic Profile - Continuation (Appointment Types) screen

This last screen displays all appointment types selected for this place of care through the PLAC option.

```
HOSPITAL LOCATION: ACUTE CR MTF         SD CLINIC PROFILE - CONTINUATION

 Select APPOINTMENT TYPE:
 CON
 FOL
 NEW
 T-CON*


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO
```

Figure 2-71. SD Clinic Profile - Continuation (Appointment Types) Screen

Review the information. If incorrect, you may also access the PLAC option to edit.

File the data

You do not have to access any of the appointment types and may bypass them by pressing the down-arrow key until you can file the data.

Enter another place of care or file and continue to provider agreements

After filing the data, the system returns you to the original GRP PRO1 screen and positions the cursor one slot below the place of care name. You can add additional places of care. If you press <Return> while the cursor is in this initial position, the system allows you to file this information and continue on to the next phase of building a group network; i.e., entering provider agreements.

- **Functionality Interactions**

While building network providers, you should not edit any area of the PAS and MCP profiles, but you must press <Return> to advance through all fields to ensure pointers are set. You may need to add some information, but do not edit information unless specifically mentioned above.

The places of care and providers entered in a group must match. The providers must be in the PAS profiles of those clinics.

- **Troubleshooting**

Problem – Problems are encountered with the profiles.

Solution – Edit the profile information through the GNET or the PLAC options.

2.2.1.2 GNET – Agreements Entry

Menu Path: PAS System Menu → M → PMCP → GNET

- **Security Keys**

CPZ CCP
CPZ FILE
CPZ AGREEMENT
CPZ LOWCAP
CPZ NET

- **Required Fields**

Agreement Type
Effective Date
Stop Date
Overall Discount
Overall Discount Percent

- **Application Description**

The agreement data entered should be the agreement types used by all providers within this group. Agreement types are applicable to certain patient/beneficiary types.

- **Business Rules**

– Providers may participate with certain agreement types restricting them to certain patient types. Refer to Appendix A, Table A-5. External (Non-MTF) Provider Agreement Types and Eligible Patient Types.

– Enrollees may be assigned only to PCMs who are parties to an allowable agreement type for their patient type status; e.g., AD may not be enrolled to providers who are parties only to partner internal (PIC) agreements.

– Beginning with CHCS Version 4.6, the system allows assignment of PCMs from the contractor network with the agreement types, civilian network provider (NET) and supplemental care/diagnostic service (SUP) when enrolling active-duty beneficiaries. (Before CHCS Version 4.6, the system only allowed active-duty beneficiaries to be assigned to direct-care PCMs with the agreement types of MTF (MTF staff) and contract (CON). A Security key is required in order to assign active-duty to NET of SUP agreements.

– The capability of network PCM assignment for active-duty applies in both reassignment as well as interactive PCM assignment functions.

– Only those agreement types that are assigned a PCM status by the site are allowable for PCM assignment. If the group is a PCM, only the agreements so designated by the site are allowable for enrollment. If individual or group providers are to be PCMs, only the PCM agreements in which they participate allow patients to be assigned to them.

- **Other Important Considerations**

When selecting the agreement to assign PCM status, remember that providers with desired specialties display as allowable only for the patients associated with the agreement type; e.g., PIC is not an allowable agreement type for AD so that any provider whose specialty was needed but who only participated in a PIC agreement would not display for selection. Refer to Appendix A, Table A-5: External (Non-MTF) Provider Agreement Types and Eligible Patient Types.

Prior to terminating a group or provider agreement type, reschedule any patient appointments currently booked with the provider with that agreement type.

Maintaining agreements requires constant monitoring especially with civilian, non-MTF providers. The MTF may assume the maintenance of these agreements in accordance with terms of the TRICARE contract.

Managed care policies that can be set and enforced through the agreements are enrollment mix, beneficiary mix, age constraints, and total beneficiaries allowed for the group per agreement.

- **Data Entry Process**

Enter a new agreement for a provider group

Access the GNET option

Enter the name of the provider group

Access the Provider Group Profile/Agreement Maintenance screen and the (A)greements action

Complete Provider Group Agreement History screen actions:
- **(S)pecialty Exceptions**
- **(C)PT-4 Exceptions**
- **Enrollment (M)ix**
- **(T)erminate**

Access the GNET option
Enter the name of the provider group

Access the Provider Group Profile/Agreement Maintenance screen and the (A)greements action

The system displays the GRP PRO1 screen with the cursor at the Short Group ID field. Refer to Figure 2-65. GRP PRO1 - Provider Group Profile Screen, page 2-166.

Press the down-arrow key until the cursor is under the last place of care name and then press <Return>.

File the data.

The system displays the Provider Group Profile/Agreement Maintenance screen with the action bar. Refer to Figure 2-72. Provider Group Profile/Agreement Maintenance Action Bar, page 2-177.

```
Action Bar: Select (A)greements, (P)roviders, (I)nactivate/
Reactivate, or (Q)uit: A//
```

Figure 2-72. Provider Group Profile/Agreement Maintenance Action Bar

Press <Return> to accept the default (A)greements action.

The system displays the Provider Group Agreement History screen. Refer to Figure 2-73. Provider Group Agreement History Screen, page 2-177.

Complete Provider Group Agreement History screen actions

The Provider Group Agreement History screen is a three-part screen. The top portion displays the provider group name. The middle portion displays fields labeled Agreement Type, Effective Date, Stop date, Overall Discount, FI Notified, Except, PCM. The bottom part is the action bar. The action bar displays only two prompts initially. You may press <Return> to accept the default (A)dd action, or enter "Q" for Quit.

```
                        PROVIDER GROUP AGREEMENT HISTORY


Provider Group: ACUTE CR MTF
-------------------------------------------------------------------------------
-
 Agreement  Effective                      Overall      FI
   Type       Date          Stop Date     Discount  Notified      Except   PCM




Select (A)dd, or (Q)uit Agreements: A//
```

Figure 2-73. Provider Group Agreement History Screen

1. Press <Return> to accept the default (A)dd action.

The middle portion of the screen displays the *<---NEW Agreement may be added here* prompt.

2. Enter the agreement [con] and press <Return>.

At least one agreement type must be entered for the group.

3. Enter "YES" at the *Are you adding 'CON' as a new AGREEMENT TYPE (the 1st for this MCP PROVIDER GROUP)*? prompt.

When you enter "YES," you are prompted to enter the date this agreement becomes effective.

4. Enter the effective date for the new agreement type.

Enter the start date of the agreement. If this is an MTF agreement, enter "T" for today, a past date, or a future date. After entering a date press <Return>. The next query is whether you are adding this date as a new period of agreement for this agreement type.

5. Enter "YES" at the *Are you adding '21 Jun 2001' as a new PERIOD OF AGREEMENT (the 1st for this AGREEMENT TYPE)?* prompt.

When you answer "YES," the system displays a subscreen, GRP AGREE2 – Provider Group Overall Discount. Refer to Figure 2-74. GRP AGREE2 - Provider Group Overall Discount Screen, page 2-179.

The top portion of this screen displays the effective date chosen for this agreement, screen name, and provider group name. The second portion displays the fields Agreement Type, Effective Date, Stop Date, Overall Discount, and FI Notified. You may move from field to field by pressing <Return> or the up-arrow and down-arrow keys.

The fields Agreement Type and Effective Date have data defaulted from the previous screen and cannot be edited. The cursor is positioned at the Stop Date field.

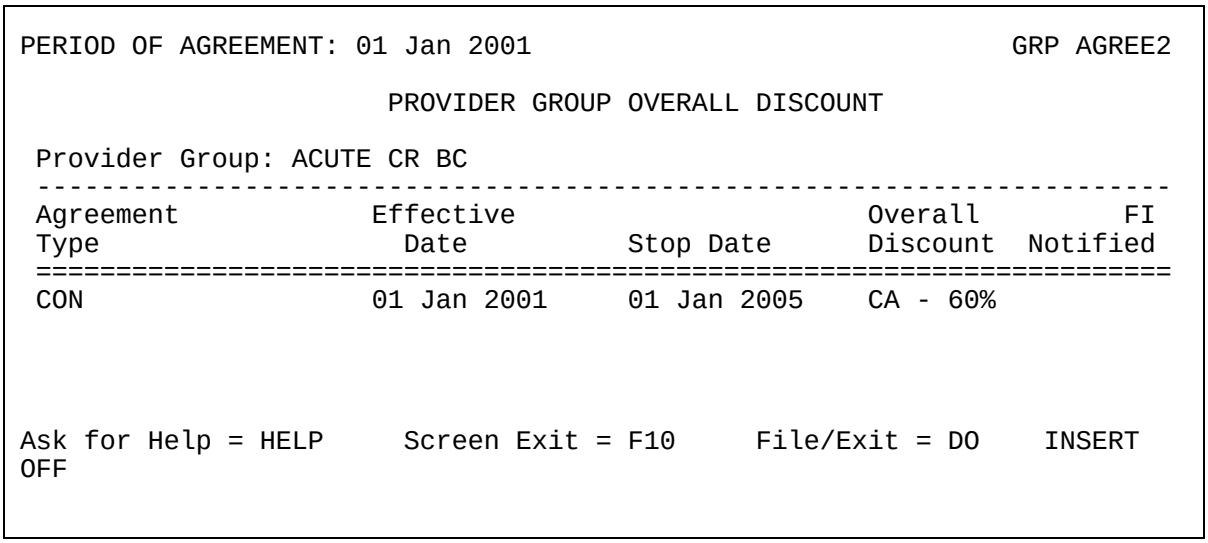


Figure 2-74. GRP AGREE2 - Provider Group Overall Discount Screen

1. Stop Date

A defaulted date of one year from the agreement start date entered in the previous screen. You should edit this date if this agreement/memorandum of understanding (MOU) is for a shorter or longer period.

2. Overall Discount

The Overall Discount should be any discount this group provides for MTF-referred patients and is expressed in percent (%). The default is CA for CHAMPUS Allowable but may be changed to U for Usual and Customary charges. MTF agreement type always defaults to 100% of CA. All other agreement types have a blank field, allowing you enter the correct discount, if any. A discount is necessary and may be edited later. In earlier CHCS versions, the discount was important because the higher discounts displayed first during provider searches. CHCS Version 4.5 now displays providers differently and is covered in another section. A discount of zero (0) percent for civilian providers indicates the specific provider is a non-network provider with an agreement type of NON.

3. FI Notified

FI Notified is the date the Fiscal Intermediary (Region Lead Agent in most cases) was notified of this agreement. If there is no FI, you may leave this field blank.

4. File the data.

After filing this screen, if the group does not yet have providers attached, the system returns you the Provider

Group Enrollment History screen and to the prompt to enter a new agreement type. Refer to Figure 2-73. Provider Group Agreement History Screen, page 2-177.
You may enter a new agreement at the Provider Group Agreement History screen and repeat the above process for each agreement in which the members of this group may participate.
If the group already has providers attached, the system displays the Individual Provider Agreement Participation screen with the provider names displayed in the middle Select Window. Refer to Figure 2-75. Individual Provider Agreement Participation Screen, page 2-180.

```
                  INDIVIDUAL PROVIDER AGREEMENT PARTICIPATION

    Provider Group: ACUTE CR BC
    Agreement Type: CIVILIAN NETWORK PROVIDER
Dates of Agreement: 01 Jan 2001  -  31 Dec 2001
  Overall Discount: 68%
--------------------------------------------------------------------------------
-
   Provider Name

   ARRIBA,GILBERT M
   BEALE,SHARON M
   CRAWFORD,KYLE M
   DELL,ALICE M
   EDROZO,FRANK M
   FIESTA,LUISA M
+  GOTT,JOHN M

Use SELECT key to select individual provider(s) who do NOT participate in this
group agreement.  If all providers in this group participate in this agreement,
press <RETURN> to continue.
```

Figure 2-75. Individual Provider Agreement Participation Screen

1. Press <Select> to mark the providers who DO NOT participate in this NEW agreement.
If providers have not been attached to this provider group, this screen does not display.
2. Press <Return> twice to exit the Individual Provider Agreement Participation screen.
The system redisplays the Provider Group Agreement History screen. Refer to Figure 2-76. Provider Group Agreement History Screen, page 2-181.
All information entered in the subscreen now displays on the Provider Group Agreement History screen.

```
                        PROVIDER GROUP AGREEMENT HISTORY
```

```
Provider Group: ACUTE CR BC
------------------------------------------------------------------------------
-
 Agreement  Effective                      Overall      FI
   Type       Date          Stop Date     Discount  Notified      Except   PCM

   PIC      01 Jan 2001     01 Jan 2005   CA- 40%
   MTF      01 Jan 2001     01 Jan 2005   CA-100%                            Y
   NET      01 Jan 2001     01 Jan 2005   CA- 25%                            Y
   SUP      01 Jan 2001     01 Jan 2005   CA                                 Y
   CON      01 Jan 2001     01 Jan 2005   CA- 60%



Select (A)dd, (E)dit, (S)pecialty Exceptions, (C)PT-4 Exceptions,
       Enrollment (M)ix, (T)erminate, (R)enew, or (Q)uit Agreements: Q//
```

Figure 2-76. Provider Group Agreement History Screen

The top Display Window displays the provider group name
The middle Select Window displays type of agreement, overall discount, and agreement effective dates, overall discount percent, and FI notification date, specialty exceptions, and whether the group is a PCM for any of the agreement types.
The bottom Interact Window contains an action bar with the following actions:

– (A)dd - Returns you to the middle Select Window to add new agreements.

– (E)dit - Allows you to edit existing agreements seen in the Select Window. The cursor moves into the Select Window and allows you to move up and down, using the up-arrow and down-arrow keys. When you identify the desired agreement, press <Select>. An asterisk (*) displays next to your selection. Press <Return> to access the subscreen for editing.

– (S)pecialty Exceptions - Allows you to enter a provider specialty for which this agreement has a pricing exception (e.g., a family practice group has a different discount for OB-GYN). If you select this choice, the system displays the Provider Group Specialty Exceptions subscreen. Refer to Figure 2-77. Provider Group Specialty Exceptions Subscreen, page 2-183.

– (C)PT-4 Exceptions - Allows you to enter procedures the provider supplies at a special discount. When you select this action, the system displays the Provider Group Procedure Exceptions screen where you can add a block of

procedures or a single procedure. Refer to Figure 2-78. Provider Group Procedure Exception Screen, page 2-184.

– Enrollment (M)ix - Allows you to designate the maximum number of patients this group may enroll by agreement type and to designate the agreement as a PCM agreement. If this group and its providers are not to be PCMs, this action may be bypassed. If the providers are to serve as PCMs, this action should be selected. When you select this action, the cursor is repositioned in the middle Select Window, allowing you to select the agreement to define. Press <Select> to mark the agreement you wish to define. Press <Return> to activate your selection. The system displays the Provider Group PCM Capacity subscreen. Refer to Figure 2-79. Provider Group PCM Capacity Subscreen, page 2-185.

– (T)erminate - Allows you to enter a termination date for an agreement. If selected, the cursor is positioned in the middle Select Window, allowing you to select the agreement to terminate. After selection, the system displays the Agreement Early Termination Reason subscreen. Refer to Figure 2-81. Agreement Early Termination Reason Subscreen, page 2-188. After an agreement termination date, that agreement in the specified provider group is no longer available for PCM assignment.

– (R)enew - Allows you to enter a renewal date and a stop date.

(S)pecialty Exceptions - The Provider Group Specialty Exceptions screen displays when you choose the (S)pecialty Exceptions action on the Provider Group Agreement History action bar.

```
                    PROVIDER GROUP SPECIALTY EXCEPTIONS

    Provider Group: ACUTE CR BC
    Agreement Type: CONTRACT
Dates of Agreement: 01 Jan 2001  -  01 Jan 2005
  Overall Discount: CA- 60%
--------------------------------------------------------------------------------
-
   Specialty                      Effective                 Discount    FI
   Description                      Date       Stop Date    Percent  Notified




_____________________ No Exception data found _____________________________
Select (A)dd, or (Q)uit Specialty Exceptions: A//
```

Figure 2-77. Provider Group Specialty Exceptions Subscreen

The top Display Window lists the provider group name, a specific agreement type, dates of the agreement, and overall discount rate.

The middle Select Window shows the description of the exception specialty, effective date, stop date, percent discount applicable to this specialty, and when the FI was notified.

The bottom Interact Window contains an action bar with the choices to (A)dd a specialty or (Q)uit. If there are already exception specialties listed in the Select Window, you will have additional choices to (E)dit or (D)elete.

1. When you choose the (A)dd action, the system positions the cursor in the Select Window.
2. After adding the specialty, you are asked if this is a new specialty. If you answer "YES" the system displays a second subscreen, Provider Group Specialty Exception – GRP EXE1. Refer to Figure 2-77. Provider Group Specialty Exceptions Subscreen, page 2-1.
3. Add a discount for this specialty.
4. Select the (Q)uit action to return to the Provider Group Agreement History screen.

(C)PT Exceptions - The system displays the Provider Group Procedure Exceptions screen when you choose the (C)PT-4 Exceptions action on the Provider Group Agreement History screen. Refer to Figure 2-78. Provider Group Procedure Exception Screen, page 2-184.

```
                    PROVIDER GROUP PROCEDURE EXCEPTIONS

    Provider Group: ACUTE CR BC
    Agreement Type: PARTNER INTERNAL
Dates of Agreement: 01 Jan 2001  -  01 Jan 2005
  Overall Discount: CA- 40%
--------------------------------------------------------------------------------
-
   CPT-4                                Effective     Stop    Disc/         FI
   Code   Description                     Date       Date     Fee       Notified




                           No Exception data found
Select (B)lock add, (S)ingle add, or (Q)uit Procedure Exceptions: S//
```

Figure 2-78. Provider Group Procedure Exception Screen

The top Display Window lists the provider group name, agreement type, dates of the agreement, and overall discount rate for the agreement.

The middle Interact Window lists the CPT-4 code for procedure exceptions, procedure descriptions, effective date, stop date, discount/fee, and date FI was notified.

The middle Select Window is an action bar with three actions: (B)lock add, (S)ingle add, or (Q)uit.

1. If you select the (B)lock action:

a) You are prompted for a starting CPT code, then an ending CPT code.

b) After both are entered, the system displays a Proc Block subscreen. Edit the defaulted start and stop dates (from the Agreement) and enter a fee or different discount fee.

2. If you select the (S)ingle action, the system displays the GRP EXE3 subscreen after selecting a single CPT code. Here you may enter a discount fee or percentage discount for this specific procedure.

3. You may then return to the Provider Group Procedure Exception screen (refer to Figure 2-78. Provider Group Procedure Exception Screen, page 2-184) where you can see additional action bar choices to (E)dit and (D)elete Procedure Exceptions.

Choose the (Q)uit action to return to the Provider Group Agreement History screen.

Enrollment (M)ix -

When you choose the Enrollment (M)ix action on the Provider Group Agreement History action bar, the system

displays the Provider Group PCM Capacity screen with the cursor at the Maximum Patient Capacity field. Refer to Figure 2-79. Provider Group PCM Capacity Subscreen, page 2-185.

This screen displays the provider group name, the agreement type you selected from the Provider Group Agreement History screen, the agreement start and stop dates, and whether the group has been activated as a PCM. Capacities for PCMs should be coordinated with the MOUs in the TRICARE contract to ensure they are consistent.

```
                          PROVIDER GROUP PCM CAPACITY

     Provider Group: ACUTE CR BC
     Agreement Type: CON - CONTRACT
 Dates of Agreement: 01 Jan 2001 - 01 Jan 2005
 Activate Group PCM: NO

 Maximum Patient Capacity:           Age Range to Apply Overall:     -
           Total Assigned:
================================================================================
=
                                                                  Total     Pat Out of
 Enrollment Mix                     Age Range   Capacity   Assigned   Age Range
--------------------------------------------------------------------------------
-
  ACTIVE DUTY                          -
  ACTIVE DUTY FAMILY MEMBER            -
  RETIREE                              -       0
  RETIREE FAMILY MEMBER                -       0
  MEDICARE
  OTHER                                -




 Help = HELP      Exit = F10     File/Exit = DO                      INSERT OFF
```

Figure 2-79. Provider Group PCM Capacity Subscreen

1. Maximum Patient Capacity

This number should be the maximum number of patients that can be assigned to this PCM for this agreement. **(If left blank, the capacity defaults to unlimited.)**

2. Age Range

Enter age range to apply to all patient types. This number should be the minimum and maximum age to assign for this agreement.

3. Total Assigned

The system bypasses this field, which is cannot be edited. This field is incremented and decremented by the system as patients are enrolled/disenrolled to this PCM agreement type.

4. Enrollment Mix

Enter beneficiary types that will be enrolled to this agreement. If a beneficiary type is not entered here, the system does not allow enrollment of any beneficiaries of that type to this PCM agreement. The beneficiary types are:

ADY	Active Duty
AFM	Active Duty Family Member
RET	Retiree
MED	Medicare
RFM	Retiree Family Member
OTH	Other

In CHCS Version 4.5, AD patients could not be assigned to a PCM with agreement types NET and SUP. For these two agreement types, the Capacity field was automatically set to non-editable 0 (zero) under active duty capacity. In CHCS Version 4.6, the Active Duty capacity field is set to null as a default, allowing users to enter data in Active Duty capacity and age range fields.

Note: PCM capacities for NET and SUP agreement should be reviewed and updated if necessary. The default capacities were set to unlimited (the effect of null).

For each beneficiary type entered, complete steps 5 through 10.

5. Age Range

Age range is a optional field that allows you to limit PCM assignment by age for this agreement type. If blank, no restrictions by age.

6. Capacity

Optional field that allows you to limit PCM assignment by beneficiary type for this agreement type. If blank, capacity is unlimited up to the PCM maximum overall capacity. If the PCM overall capacity is blank also, capacity is unlimited up to the group's overall capacity.

7. Total Assigned

This field constantly changes as the patient population is assigned and reassigned to this PCM. This field cannot be edited.

8. Pat Out of Age Range

Also a field that cannot be edited, indicates there are patients assigned to this PCM who are outside the age range allowed for this agreement type.

When you complete data entry for all beneficiary types seen by this provider group, another Provider Group PCM Capacity subscreen displays. Refer to Figure 2-80. Provider Group PCM Capacity Subscreen, page 2-187.

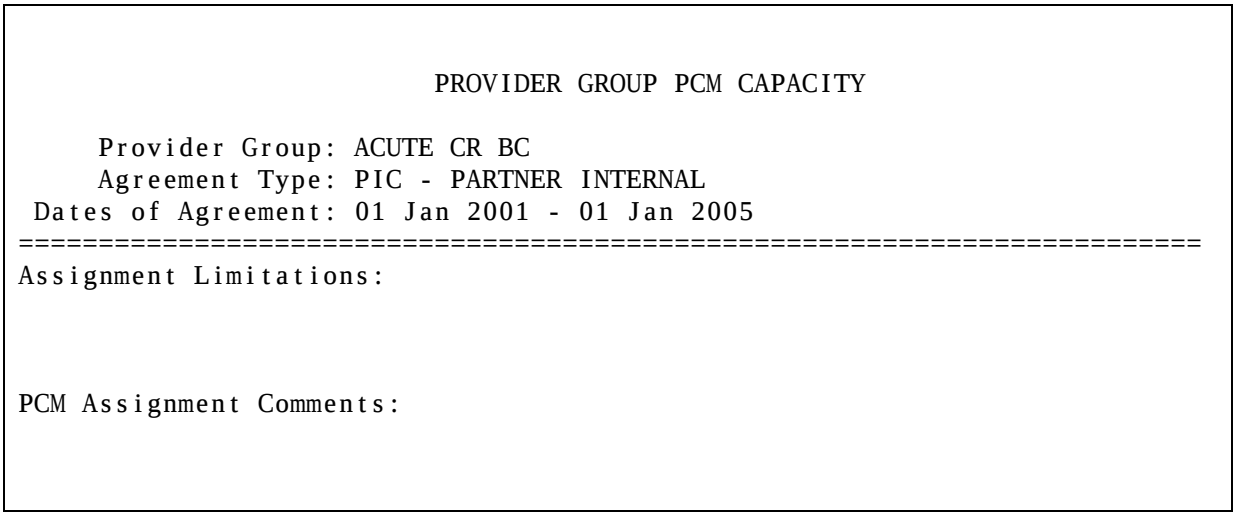


Figure 2-80. Provider Group PCM Capacity Subscreen

1. Assignment Limitations

Optional, free-text field. Allows you to enter comments on the PCM assignment limitations that apply to providers in this group and to the group provider (e.g., clients exclusive to San Diego). Group limitations can be overriden by provider-specific assignment limitations.

2. PCM Assignment Comments

Also an optional, free-text field (e.g., family PCM care encouraged, large hispanic client population, complete patient services). Group PCM assignment comments can be overriden by provider-specific PCM assignment comments.

3. File the data.

The system returns to the Provider Group Agreement History screen.

(T)erminate -

When you choose the (T)erminate action on the Provider Group Agreement History screen, the system displays the Agreement Early Termination Reason subscreen. Refer to Figure 2-81. Agreement Early Termination Reason Subscreen, page 2-188.

The top Display Window of this screen lists the provider group name, the agreement type, and the effective dates of the agreement. The cursor is positioned at the New Stop Date field just below the double dotted line.

```
PERIOD OF AGREEMENT: 01 Jan 2001                                GRP AGREE2

                        AGREEMENT EARLY TERMINATION REASON

    Provider Group: ACUTE CR BC
    Agreement Type: CON - CONTRACT
 Dates of Agreement: 01 Jan 2001  -  01 Jan 2005
 ========================================================================
             New Stop Date: 01 Jan 2005
          Date FI Notified:

 Reason for terminating agreement earlier than expiration date:


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO   INSERT OFF
```

Figure 2-81. Agreement Early Termination Reason Subscreen

1. New Stop Date

This date defaults with the original stop date. It may be changed here to either earlier or later than the original date. If earlier than the original date, a response in the Reason for Early Termination field is required.

2. Date FI Notified

This field stores the date the FI was notified of the agreement termination.

3. Reason for terminating agreement earlier than expiration date

A free-text field required on early terminations.

4. File the data.

After you file the data, the system returns to the Provider Group Agreement History screen.

After all provider group agreement data has been entered, the Provider Group Agreement History screen shows all of the agreements with start and stop dates, discounts and which (if any) agreements for the group are designated as PCM agreements. The Except field remains blank unless the following exceptions for the specified group agreement have been entered:

– Agreements with Specialty Exceptions (displays an "S").

– Agreements with CPT code Exceptions (displays a "C").

Exit the Agreements action by entering "Q" for (Q)uit at the Provider Group Agreement History action bar.

The system redisplays the Group Profile/Agreement Maintenance screen. Refer to Figure 2-72. Provider Group Profile/Agreement Maintenance Action Bar, page 2-1.

Choose the (P)rovider action and add/edit the group providers.

Exit the option or continue defining the providers

- **Functionality Interactions**

PAS appointment booking interacts with MCP.

- **Troubleshooting**

If a patient cannot be assigned a PCM, check:

– Has the capacity been reached in the agreement enrollment mix?

– Is the beneficiary type one that this PCM and agreement type can support?

– Has the agreement expired or does it have a future effective date? A beneficiary may be assigned a PCM on a future date provided the PCM agreement start date is earlier than the enrollment start date.

2.2.1.3 GNET – Providers

Menu Path: PAS System Menu → M → PMCP → GNET

- **Security Keys**

CPZ CCP

CPZ FILE
CPZ AGREEMENT
CPZ LOWCAP
CPZ NET

- **Required Fields**

Provider Name
Gender
Rank
Professional Category
Provider Type
Place of Care
Max # of Appts Per Day
Print Roster With Open Appts

- **Application Description**

This phase of building a provider network identifies the individual providers attached to the place(s) of care within a group. This phase defines provider agreement participation, exceptions, and enrollment mix allowed if the individual provider is designated a PCM. If the group is to be a PCM, this option defines those areas as well.

- **Business Rules**

– All providers for the place of care must be defined here, including the group provider if it is to be a PCM.
– MTF providers defined as being in this place of care must also be assigned to the corresponding PAS clinic through PAS software.
– If reassigned from one MTF place of care to another, providers must be inactivated from the first MTF place of care, then redefined in the new MTF place of care from this menu option or the Individual Provider Profile/Agreements Enter/Edit (INET) option.
– Providers may participate in more than one agreement type. For example, a provider may participate in an MTF agreement and a CON agreement.

- **Other Important Considerations**

Details of an agreement/MOU with civilian providers may be maintained through this option and used in supplemental care and managed care cases.
Maintenance of the group requires constant attention as providers and agreements are in a constant state of flux.

- **Data Entry Process**

Associate providers with a provider group

Access the GNET option

Enter the group name

Access the (P)roviders action on the Provider Group Profile/Agreement Maintenance action bar

Complete the Individual Provider Profile screen

Complete the IND PROF1 - Individual Provider Profile screen

Complete the IND PROF3 - Individual Provider Profile screen

Complete the IND PROF4 - Individual Provider Profile screen

Complete the IND PROF5 - Individual Provider Profile screen

Complete the IND PL1 - Individual Provider Profile screen (Place of Care)

Complete the IND PL2 - Individual Provider Profile screen (Place of Care)

Complete the Individual Provider Services Offered Profile screen

Complete the CP NET HCP Profile – Continuation screen

Complete the Individual Provider PCM Capacity screen

Complete the Individual Provider Agreement Participation screen

Complete the Individual Provider Agreement Exception History screen

Quit the (P)roviders action

Quit and exit the option

Access the GNET option
Enter the group name
The system displays the Provider Group Profile screen. Refer to Figure 2-65. GRP PRO1 - Provider Group Profile Screen, page 2-166.
Press <Next Screen> to bypass the Provider Group Profile screen.
The system displays the Provider Group Profile/Agreement Maintenance screen. Refer to Figure 2-72. Provider Group Profile/Agreement Maintenance Action Bar, page 2-177.
Access the (P)roviders action on the Provider Group Profile/Agreement Maintenance action bar

If providers have not been defined, a message above the action bar indicates that providers must be entered for the provider group records to be complete.
When you access the (P)roviders action, the system displays the Individual Provider Profile screen. Refer to Figure 2-82. Individual Provider Profile Screen, page 2-193.

Complete the Individual Provider Profile screen

```
                        INDIVIDUAL PROVIDER PROFILE

Provider Group: ACUTE CR MTF
--------------------------------------------------------------------------------
   Provider Name
________________________________________________________________________________
   AUSTIN,GILBERT M




________________________________________________________________________________
_
Select (A)dd, (E)dit Profile, Agreement e(X)ceptions, or (Q)uit Providers: A//
```

Figure 2-82. Individual Provider Profile Screen

The top Display Window of the Individual Provider Profile screen displays the provider group name.
The middle Select Window is blank if no providers have been entered. If any providers have been entered, this window displays their names.
The bottom Interact Window contains an action bar with only two actions initially: (A)dd and (Q)uit. If at least one provider has been entered, two additional actions are available: (E)dit Profile and Agreement e(X)ceptions.

– (A)dd - Allows you to add new providers to this provider group.
– (E)dit - Allows you choose a provider profile to edit. The system positions the cursor in the Select Window. Mark the selection by pressing <Select>. After you select a provider, press <Return> to advance through all Individual Provider Profile screens for that provider.
– Agreement e(X)ceptions - Allows you to choose a provider and edit the exception data. The system positions the cursor in the Select Window. If the group is a PCM, the system does not allow you to edit group agreement exception data from this action.

Add a provider to the group

1. Select the (A)dd action.

When you select the (A)dd action, the system positions the cursor in the Select Window to the left of the *<--NEW provider may be added here* prompt.

2. Enter the name of the new provider for this place of care.

The provider name should already have been entered into the Provider and MCP Provider files through the PROV option. You cannot enter the provider name here until the provider has been entered through the PROV option (**Menu Path:** PAS System Menu → MAN → FMCP → PTAB → PROV).

3. Press <Return> to verify the new provider's name.
4. At the *Transfer all Group Places of Care to [PROVIDER NAME]? No//* prompt, enter "Y" for yes if the provider works in all of the places of care in the group.

If the provider does not work at all group places of care, press <Return> to accept the "No" default. When you accept the "No" default, the system prompts you through each group place of care, allowing you to confirm whether to transfer that place of care to the provider. This process links the provider with the places of care he may work in within the group. MTF providers must also have schedules in the clinics to which they are linked. Schedules are built using the PAS software.

After transferring places of care to the provider, the system displays the IND PROF1 - Individual Provider Profile screen. Refer to Figure 2-83. IND PROF1 - Individual Provider Profile Screen, page 2-195.

Complete the IND PROF1 - Individual Provider Profile screen

The IND PROF1 screen displays the provider SSN, and other miscellaneous data about an individual provider. All provider information required for the IND PROF1 screen has been previously entered through the PROV option, and defaults from the IND PROF1a screen into the IND PROF1 screen.

```
PROVIDER: AUSTIN,GILBERT M                                              IND
PROF1

                        INDIVIDUAL PROVIDER PROFILE

 Provider Group: ACUTE CR MTF

================================================================================
=

              SSN#: 654-66-2833             DEA#:
            Gender: MALE                    Rank: CAPTAIN
```

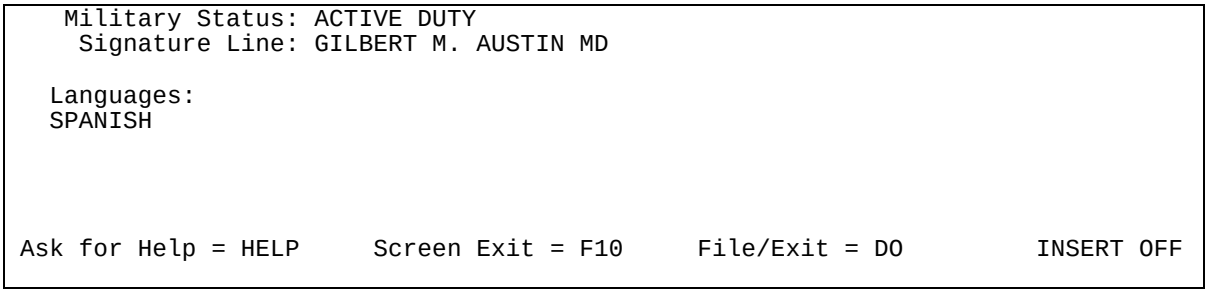


Figure 2-83. IND PROF1 - Individual Provider Profile Screen

Press <Return> to advance through all fields in the IND PROF1 screen.

Any edits required should be done through the PROV option.

When you press <Return> at the Language field, the system displays the IND PROF3 - Individual Provider Profile screen. Refer to Figure 2-84. IND PROF3 - Individual Provider Profile, page 2-197.

Complete the IND PROF3 - Individual Provider Profile Screen

The IND PROF3 screen displays identification and professional data about a provider.

All information in the IND PROF3 screen also defaults from data entered through the PROV option.

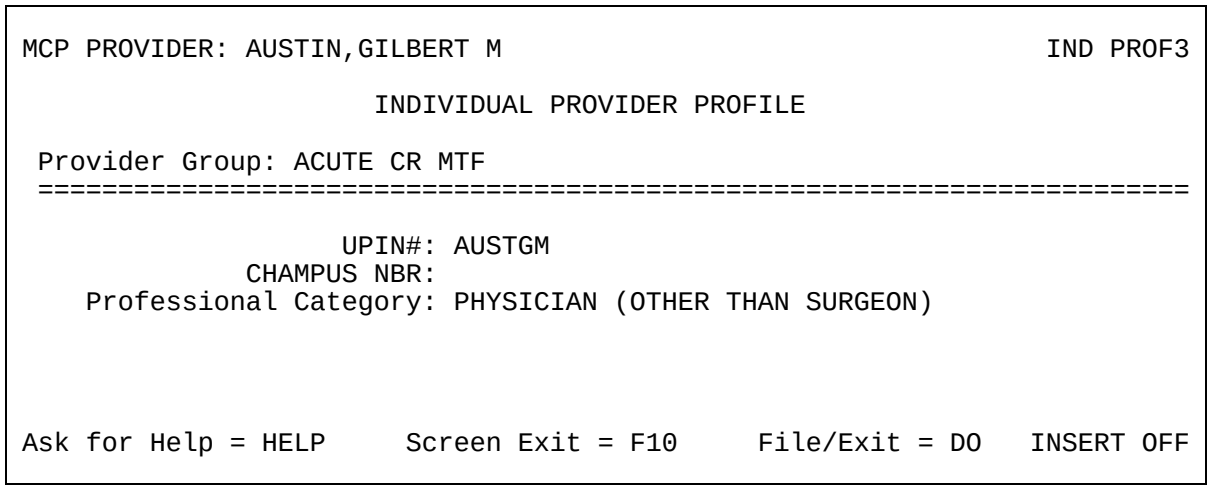


Figure 2-84. IND PROF3 - Individual Provider Profile

Press <Return> to advance through all fields in the IND PROF3 screen.

Any edits required should be done through the PROV option.

When you press <Return> at the Professional Category field, the system displays the IND PROF4 - Individual Provider Profile screen. Refer to Figure 2-85. IND PROF4 - Individual Provider Profile Screen, page 2-198.

Complete the IND PROF4 - Individual Provider Profile screen

Information defaults into the IND PROF4 screen from previously entered group information.

```
MCP GROUP PROVIDER: AUSTIN,GILBERT M                                IND PROF4

                      INDIVIDUAL PROVIDER PROFILE

 Provider Group: ACUTE CR MTF
 ============================================================================

                  Tax ID#:
            Provider Type: NETWORK INDIVIDUAL PROVIDER

 Payment Address 1: 6625 16th Street
 Payment Address 2:
       Payment Zip: 20307
      Payment City: WASHINGTON
     Payment State: DISTRICT OF COL
     Payment Phone: 202 427-1201
   Payment Contact: Billing Officer
Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT
OFF
```

Figure 2-85. IND PROF4 - Individual Provider Profile Screen

1. Tax ID#

Optional field. This should be the tax number for this provider if available. Not currently used in CHCS.

2. Provider Type

Required field. The choices are Network, Non-Network, or Single Service provider. MTF providers and civilian TRICARE providers are always Network.

3. Payment Address, ZIP, City, State, Phone, and Contact Person.

These fields should contain default information previously entered. If not, you may enter group data in these fields. Do NOT change defaulted data. Edit either the place of care (PLAC) or the group (GROU).

4. Press <Return> to advance through all fields.

After you press <Return> at the last field, the system displays the IND PROF5 - Individual Provider Profile screen. Refer to Figure 2-86. IND PROF5 - Individual Provider Profile Screen, page 2-199.

Complete the IND PROF5 - Individual Provider Profile screen

The IND PROF5 screen displays the places of care where this provider works and that have been transferred to the provider. You can only enter places of care for the provider that are linked to the specific provider group. The place of

care must be entered at the group level before it can be assigned to a provider within the same group.

```
MCP GROUP PROVIDER: AUSTIN,GILBERT M                              IND PROF5

                      INDIVIDUAL PROVIDER PROFILE

 Provider Group: ACUTE CR MTF
 ================================================================================

 Places of Care:
 ACUTE CR MTF



Ask for Help = HELP     Screen Exit = F10     File/Exit = DO
```

Figure 2-86. IND PROF5 - Individual Provider Profile Screen

Position the cursor at the desired place of care and press <Return> to access the IND PL1 - Individual Provider Profile screen. Refer to Figure 2-87. IND PL1 - Individual Provider Profile (Place of Care) Screen, page 2-200.

Complete the IND PL1 - Individual Provider Profile (Place of Care) screen

The IND PL1 screen displays this provider's specialties at this place of care if they have been previously entered through the PROV option.

```
PLACE OF CARE: ACUTE CR MTF                                          IND PL1

                      INDIVIDUAL PROVIDER PROFILE

      Provider: AUSTIN,GILBERT M
 Provider Group: ACUTE CR MTF
 ============================================================================

  Specialty(s):
  FAMILY PRACTICE PHYSICIAN



       Position cursor next to the Specialty to edit and press <RETURN>
      or to add a new entry go beneath the last line and press <RETURN>
```

Figure 2-87. IND PL1 - Individual Provider Profile (Place of Care) Screen

Specialties can be added at this time.

Press <Return> to continue to the, IND PL2 - Individual Provider Profile screen. Refer to Figure 2-88. IND PL2 - Individual Provider Profile (Place of Care) Screen, page 2-201.

If you press <Next Screen> or <Do>, the system returns to the initial Individual Provider Profile screen.

Complete the IND PL2 - Individual Provider Profile (Place of Care) screen

The IND PL2 screen displays the hours of operation for the provider's place of care. This information defaults from the place of care information entered through the PLAC option.

```
PLACE OF CARE: ACUTE CR MTF                                          IND PL2

                      INDIVIDUAL PROVIDER PROFILE

      Provider: AUSTIN,GILBERT M
Provider Group: ACUTE CR MTF
================================================================================

------------------------------Hours of Service--------------------------------

 Day of Week            AM                       PM
 MONDAY           0800 -  1200             1201  -  1700
 TUESDAY          0800 -  1200             1201  -  1700
 WEDNESDAY        0800 -  1200             1201  -  1700
 THURSDAY         0800 -  1200             1201  -  1700
 FRIDAY           0800 -  1200             1201  -  1700
                       -                        -

      Position cursor next to the Day of Week to edit and press <RETURN>
      or to add a new entry go beneath the last line and press <RETURN>
```

Figure 2-88. IND PL2 - Individual Provider Profile (Place of Care) Screen

You may edit this information by positioning the cursor where desired, then making changes.

Press <Return> to advance through the fields to access the next screen, Individual Provider Services Offered Profile screen. Refer to Figure 2-89. Individual Provider Services Offered Profile Screen, page 2-202.

Complete the Individual Provider Services Offered Profile screen

```
                INDIVIDUAL PROVIDER SERVICES OFFERED PROFILE

      Provider: AUSTIN,GILBERT M
 Place of Care: ACUTE CR MTF
Provider Group: ACUTE CR MTF
--------------------------------------------------------------------------------
-
   CPT-4
   Code   Description
_____________________________________________________


_____________  No Service(s) Offered found  _____________
Select (B)lock add, (S)ingle add, or (Q)uit CPT-4 Codes: Q//
```

Figure 2-89. Individual Provider Services Offered Profile Screen

The Individual Provider Services Offered Profile screen displays the provider's name, place of care, and provider group in the top Display Window. The middle Select Window displays CPT codes and their descriptions if the data was entered previously. The bottom Interact Window contains the action bar with the following actions:

– (B)lock add - Allows you to enter multiple blocks of CPT codes for this provider without exiting the action. If you choose this action, you are prompted to enter a beginning CPT code, then an ending CPT code. You can enter as many blocks of CPT codes as needed.

– (S)ingle add - Allows you to enter only one CPT code for this provider before exiting the action.

– (Q)uit CPT-4 codes - Allows you to exit the Individual Provider Services Offered Profile screen.

If one or more procedures have already been entered for this provider, two additional actions are available:

– (V)iew - Allows you to view a procedure's expanded description. To view a procedure, position the cursor next to that procedure and press <F9>.

– (D)elete - Allows you to delete a procedure from the provider's profile. Position the cursor beside the procedure, press <Select>, then press <Return>. Press <Return> again at the prompt, *Are you sure you want to delete'[procedure number]' as a Service Offered? No//*.

1. Enter or edit procedures as required according to the actions described above.

2. When finished, press <Return> at the prompt to add another CPT code.
3. Press <Return> to accept the (Q)uit default action.
4. Respond to the prompt, *Do you want to enter/edit PAS Provider Profile information now? Yes//*

If you answer "NO" initially, you receive a message that "no appointments can be booked for this provider until PAS provider profile information is completed."

If you answer "YES," you receive the following prompt:

5. Select (A)ctive, (I)nactive appointment types.

If you select (A)ctive type, the system displays the CP NET HCP Profile – Continuation - Continuation screen. Refer to Figure 2-90. CP NET HCP Profile - Continuation - Continuation Screen, page 2-203.

Complete the CP NET HCP Profile – Continuation screen

```
PROVIDER: AUSTIN,GILBERT M   CP NET HCP PROFILE - CONTINUATION - CONTINUATION

PROVIDER: AUSTIN,GILBERT M
CLINIC HOURS: 0800-1700
LOCATION:
MAX # OF PATIENT APPTS PER DAY: 100
APPT ARRIVAL ADVANCE TIME: 10 minutes
PROVIDER INSTRUCTIONS:
PRINT ROSTER WITH OPEN APPTS: NO, SHOW BOOKED APPTS ONLY
INACTIVATION DATE:




Ask for Help = HELP     Screen Exit = F10     File/Exit = DO          INSERT OFF
```

Figure 2-90. CP NET HCP Profile - Continuation - Continuation Screen

This screen may be blank initially until data is entered. This information pertains to the place of care the provider is linked to. The fields are:

1. Provider

Displays the provider name defaulted from previous entry. When you press <Return> at this field, the system displays a secondary screen that allows you to add a title, provider MEPRS code, duty phone, home phone, and facsimile number if not entered previously through another option.

2. Clinic Hours

Optional, free-text field for entering the provider's hours of operation.

3. Location

Optional field for entering the office/room location for this provider.

4. Max # of Appts per Day

Required field if not previously entered. The number entered here determines the maximum number of appointments that may be scheduled to this provider daily. The number should be high enough to accommodate the maximum number of patients the provider's schedule allows.

5. Appt Arrival Advance Time

Optional, informational field to advise patients how many minutes prior to the actual appointment they should arrive in the clinic.

6. Provider Instructions

Optional, informational field to advise patients of special instructions.

7. Print Roster with Open Appts

Required field. MTF clinics may elect to show Open slots and booked appointments or only booked appointments by entering either "YES" or "NO."

8. Inactivation Date

Date on which a provider is inactivated from a clinic.

Respond appropriately to the following prompt:

Want to transfer all appt types from the clinic profile? YES//

If you answer "NO," the system displays the next screen where you enter appointment types for this provider.

If you accept the "YES" default, the system displays additional prompts:

Want to display all appointment types first? NO//
Want to automatically transfer ALL appointment types? NO//

If you respond "YES" to either of these two prompts, the system continues through each appointment type in the clinic (group) profile, asking if you want to automatically transfer that appointment type to this provider:

Want to automatically transfer appointment type NEW? YES//

After responding to the last prompt, the system displays the list of appointment types transferred to this provider. Refer to Figure 2-91. Provider Appointment Types Display, page 2-205.

```
PROVIDER: ARRIBA,GILBERT MCP NET HCP PROFILE--CONTINUATION--CONTINUATION

 Select APPOINTMENT TYPE:
```

```
 CON
 FOL
 NEW
 T-CON*


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO
```

Figure 2-91. Provider Appointment Types Display

1. Position the cursor on an appointment type and press <Return> to display the appointment type profile.
2. Press the down-arrow key to bypass the appointment types and file the data.
3. After you file the data, press <Return> until you reach the Individual Provider Agreement Participation screen. Refer to Figure 2-92. Individual Provider Agreement Participation Screen, page 2-206.

Complete the Individual Provider Agreement Participation screen

This screen displays all agreements with which this group is associated. Individual providers do not need to participate in all agreements, but may do so.

If a provider is a PCM, the provider must be a participant of an agreement that has the PCM field set to Y.

```
                  INDIVIDUAL PROVIDER AGREEMENT PARTICIPATION

      Provider: AUSTIN,GILBERT M
Provider Group: ACUTE CR MTF
--------------------------------------------------------------------------------
-
 Agreement  Effective                      Overall      FI
   Type       Date          Stop Date     Discount  Notified      Except   PCM
 * PIC      01 Jan 2001     01 Jan 2005   CA- 40%
   MTF      01 Jan 2001     01 Jan 2005   CA-100%                             Y
 * CON      01 Jan 2001     01 Jan 2005   CA- 60%
Use SELECT key to select the group agreements in which this provider does NOT
participate.  If the provider participates in all of the group agreements,
press
<RETURN> to continue.
```

Figure 2-92. Individual Provider Agreement Participation Screen

1. If a provider does NOT participate in an agreement, position the cursor beside that agreement and press <Select> to mark the non-participating agreement with an asterisk (*).

Agreements marked with an asterisk (*) on this screen will NOT appear on the provider's Individual Agreement Exception History.

2. If the provider participates in all agreements, press <Return> and exit this screen to the Individual Provider Profile and the action bar.
3. Select the Agreement e(X)ceptions action from the Individual Provider Profile action bar.
The system displays in the Select Window of the Individual Provider Profile screen, a list of providers linked to this provider group. If this is the first provider entered for the group, only that provider name is listed.
4. Position the cursor beside the provider name and press <Select>. Press <Return> to display the provider's Individual Provider Agreement Exception History. Refer to Figure 2-93. Individual Provider Agreement Exception History Screen, page 2-207.

Complete the Individual Provider Agreement Exception History screen

The Individual Provider Agreement Exception History screen displays all agreements from the group in which the provider participates. The fields displayed are:
Agreement Type
Effective Date
Stop Date
Overall Discount
FI Notified
Except
PCM
You can edit the data for this provider only. The same data elements will remain unchanged at the group level.

```
                INDIVIDUAL PROVIDER AGREEMENT EXCEPTION HISTORY
      Provider: AUSTIN,GILBERT M
Provider Group: ACUTE CR MTF
--------------------------------------------------------------------------------
-
 Agreement  Effective                    Overall      FI
   Type       Date          Stop Date     Discount  Notified      Except   PCM
   MTF      01 Jan 2001     01 Jan 2005   CA-100%                            Y
Select (P)articipation Status, (E)dit Agreement, (S)pecialty Exceptions,
       (C)PT-4 Exceptions, Enrollment (M)ix, or (Q)uit Exceptions: E//
```

Figure 2-93. Individual Provider Agreement Exception History Screen

Action bar choices are:

– (P)articipation Status - Allows you to select agreements in which the provider presently participates. Press <Select> to mark the non-participating agreements. You can deselect the agreement by positioning the cursor on the agreement and pressing <Select> again.

– (E)DIT - Allows you to choose an agreement to edit for this provider. Press <Select> to mark the agreements. You can deselect the agreement by positioning the cursor on the agreement and pressing <Select> again. Any changes you make to this agreement will be solely for this provider. The Agreement will remain unchanged at the group level.
– (S)pecialty Exceptions - Allows you to add a specialty that has a different discount rate than the group agreement specifies. Select the agreement you desire and the system displays the Individual Provider Specialty Exceptions screen. At the prompt, enter the specialty and in the discount field enter the appropriate discount.
– (C)PT-4 Exceptions - Allows you to enter a CPT-4 procedure or a group of procedures that this provider offers at a different discount than the group agreement. Select the agreement you desire and enter the code(s) offered at a different discount.
– Enrollment (M)ix - Allows you to define this provider as a PCM, enter a maximum capacity for him/her, designate which beneficiary types they will see, and limit enrollments by age range.

Position the cursor beside the agreement to edit for this provider, press <Select>, then press <Return>.

The system displays the Individual Provider PCM Capacity screen. Refer to Figure 2-94. Individual Provider PCM Capacity Screen, page 2-209.

Complete the Individual Provider PCM Capacity screen

PCM capacities are established by beneficiary categories and by age on this screen.

The first four fields at the top of this screen show the provider name, provider group name, agreement type, and dates of the agreement. The cursor is positioned at the PCM field.

```
                        INDIVIDUAL PROVIDER PCM CAPACITY

           Provider: ENRIQUEZ,FRANK M
     Provider Group: ACUTE CR MTF
     Agreement Type: MTF - MTF STAFF
 Dates of Agreement: 01 Jan 2001 - 01 Jan 2005
                PCM: YES

 Maximum Patient Capacity: 500     Age Range to Apply Overall:     -
            Total Assigned: 1
================================================================================
=
                                                                 Total     Pat Out of
 Enrollment Mix                     Age Range   Capacity   Assigned   Age Range
```

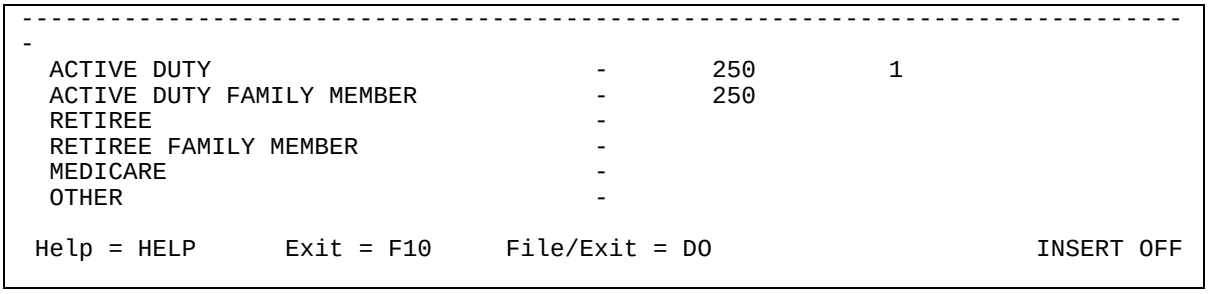


Figure 2-94. Individual Provider PCM Capacity Screen

1. PCM

Enter "YES" or "NO" to indicate whether this specific provider is designated as a PCM.

2. Maximum Patient Capacity

The default is 500.

3. Age Range to Apply Overall

Enter the age default range of patients this provider will accept. The default will be applied to all patient types.

For each patient type, complete steps 4 through 6:

4. Age Range and Capacity

Enter the age range and capacity for each of the patient types this provider will see.

5. Total Assigned

Maintained automatically by the system, as patients are enrolled, disenrolled, or reassigned to a different provider/provider group.

The system displays the second page of the Individual Provider PCM Capacity screen.

6. Assignment Limitations
7. Assignment Comments

Optional, free-text fields to describe any assignment limitations specific to this provider.

Quit the (P)roviders action

Enter (Q)uit at every action bar until you reach the *Select Provider Group* prompt.

Quit and exit the option

Press <Return> at the *Select Provider Group* prompt to return to the Provider Network Management Menu.

The procedures above for entering new agreements and new providers are also the procedures to edit agreements and providers agreements within the group. The procedure for activating a PCM is listed in the following section.

- **Functionality Interactions**

Entering agreements and providers is essential for MCP booking and enrollments. If not entered correctly, MCP patients may not be properly enrolled.

Schedules for MCP "MTF" providers are built using the PAS functionality. Based on the search criteria entered when booking appointments in MCP, the appropriate MTF provider schedules display.

- **Troubleshooting**

If providers cannot be seen when assigning a PCM to an enrolled patient or when booking, you must go through each agreement and provider profile to ensure they are PCMs, capacity is correct, they are attached to the correct place of care, and they have the correct specialty. The Provider Group Report will print this data so it can be reviewed easily for a selected provider. Refer to Figure 2-120. Provider Group Report - Places of Care, page 2-249. If unable to enroll a patient because of network data, review the enrollment mixes for the group/provider as well as the agreement and specialty of the provider.

2.2.1.4 GNET – Inactivation/Reactivation

Menu Path: PAS System Menu → M → PMCP → GNET → Provider Group → GRP PRO1 screen → Provider Group Profile/Agreement Maintenance screen → Inactivate/Reactivate

- **Security Keys**

CPZ CCP
CPZ FILE
CPZ AGREEMENT
CPZ LOWCAP
CPZ NET

- **Required Fields**

Inactivation Date
Reason for Inactivation/Reactivation

- **Application Description**

This action is used to inactivate a place of care, or individual providers within MCP. This does not inactivate them for DBA or inactivate them in PAS if present there.

- **Business Rules**

– Inactivation/Reactivation of providers or places of care occur immediately on the inactivation/reactivation date.

– CPZMGR mail group members are responsible for resolving discrepancies listed on the Discrepancy Avoidance Report following provider or place of care inactivations.

- **Other Important Considerations**

None

- **Data Entry Process**

Inactivate/Reactivate an MCP place of care for one provider

Access the GNET option

Access the Provider Group Profile Agreement screen

Press <Next Screen>

Complete the inactivation/reactivation action

File the data

Queue the report to run during non-peak hours

Exit the option

Access the GNET option
Access the Provider Group Profile Agreement screen

```
              PROVIDER GROUP PROFILE/AGREEMENT MAINTENANCE


Provider Group:
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,




,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Select Provider Group:
```

Figure 2-95. Provider Group Profile/Agreement Maintenance Screen

1. Provider Group

The system displays the Provider Group Profile for the selected Provider Group. Refer to Figure 2-96. Provider Group Profile (GRP PRO1) Screen, page 2-1. The Provider Group Profile screen includes a list of places of care linked to the selected provider group.

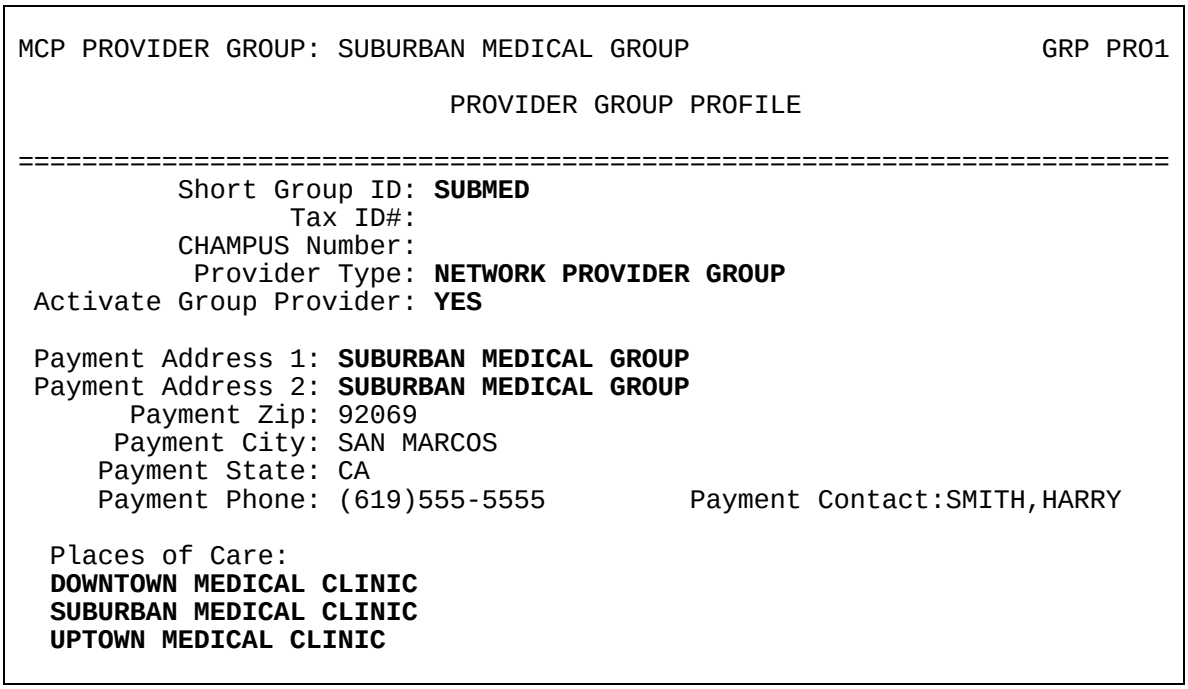


Figure 2-96. Provider Group Profile (GRP PRO1) Screen

Press <Next Screen>

The system displays the Provider Group Profile/Agreement Maintenance screen. Refer to Figure 2-97. Provider Group Profile/Agreement Maintenance Screen with Inactivate/Reactivate Action Bar, page 2-214.

Complete the inactivation/reactivation action

```
              PROVIDER GROUP PROFILE/AGREEMENT MAINTENANCE


Provider Group: SUBURBAN MEDICAL GR0UP
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,




,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Select (A)greements,(P)roviders,(I)nactivate/Reactivate, or (Q)uit: A//
```

Figure 2-97. Provider Group Profile/Agreement Maintenance Screen with Inactivate/Reactivate Action Bar

Actions on the Provider Group Inactivate/Reactivate Maintenance action bar are:

– (G)roup Place of Care - Allows you to inactivate a place for care for all providers within the group.

– (P)rovider Place of Care - Allows you to inactivate a place of care for a specific provider.

– (I)nactivate Provider - Allows you to inactivate a provider.

– (Q)uit - Allows you to quit and return to the Provider Group Profile/Agreement Maintenance screen.

Enter I to select the (I)nactivate/(R)eactivate action on the Provider Group Profile/Agreement action bar.

The system replaces the action bar on the Provider Group Inactivate/Reactivate Maintenance screen. Refer to Figure 2-98. Provider Group Inactivate/Reactivate Maintenance Screen with Inactivation Action Bar, page 2-215.

```
          PROVIDER GROUP INACTIVATE/REACTIVATE MAINTENANCE


Provider Group: SUBURBAN MEDICAL GROUP
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,





,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Select (G)roup Place of Care,(P)rovider Place of Care,(I)nactivate
Provider, (R)eactivate Provider,
       or (Q)uit: Q//
```

Figure 2-98. Provider Group Inactivate/Reactivate Maintenance Screen with Inactivation Action Bar

Enter P to select the (P)rovider Place of Care action.

The system displays an alphabetical list of the places of care linked to the specified provider group. Refer to Figure 2-99. Individual Provider Profile Inactivate/Reactivate Screen, page 2-215.

```
INDIVIDUAL PROVIDER PROFILE INACTIVATE/REACTIVATE

Provider Group: SUBURBAN MEDICAL GROUP
 Place of Care:
----------------------------------------------------------------------
   Place of Care
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
   DOWNTOWN MEDICAL CLINIC
   SUBURBAN MEDICAL CLINIC
   UPTOWN MEDICAL CLINIC




,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Use SELECT key to select Place of Care to inactivate/reactivate or
Press <RETURN> to continue
```

Figure 2-99. Individual Provider Profile Inactivate/Reactivate Screen

Select the Place of Care to inactivate.

Use the arrow keys to position the cursor beside the provider name, press <Select>, then press <Return>.

The system replaces the Place of Care names in the middle Select Window with an alphabetical list of provider names linked to the selected clinic. Refer to Figure 2-100. Provider Profile Inactivate/Reactivate Screen with Providers Linked to Place of Care, page 2-1.

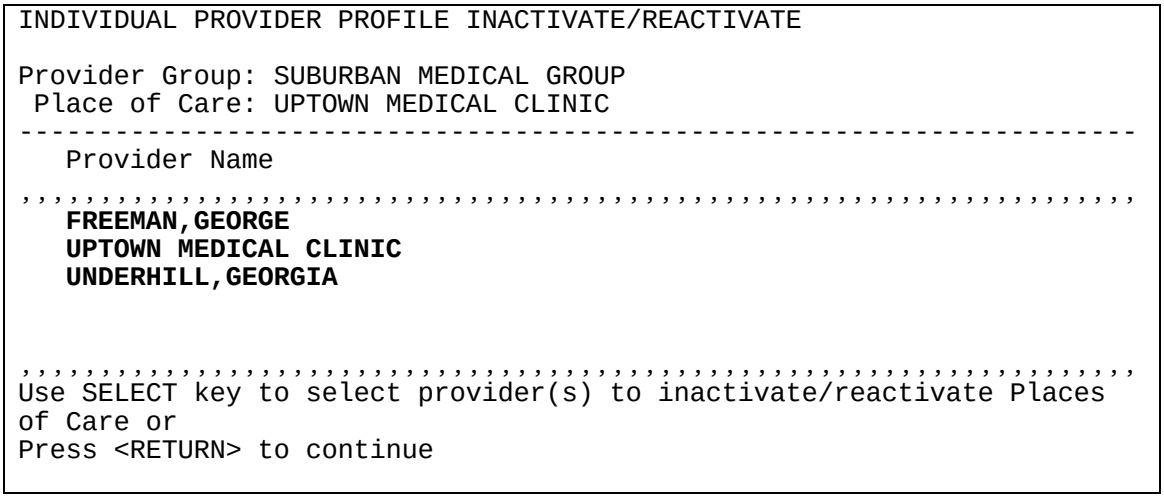


Figure 2-100. Provider Profile Inactivate/Reactivate Screen with Providers Linked to Place of Care

Select the provider for which you are inactivating the Place of Care.

Use the arrow keys to position the cursor beside the provider name, press <Select, then press <Return>.

The system displays the Inactivation/Reactivation of Place of Care screen where you can enter either an inactivation date or a reactivation date. Refer to Figure 2-101. Inactivation/Reactivation of Place of Care Screen, page 2-216.

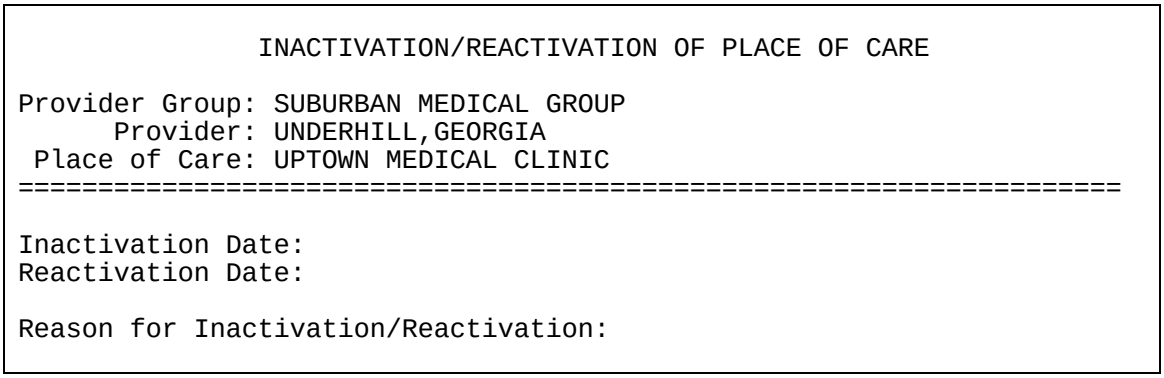


Figure 2-101. Inactivation/Reactivation of Place of Care Screen

1. Inactivation Date

You may enter a past date, today's date, or a date in the future. On the inactivation date entered, the place of care inactivation for the selected provider becomes effective immediately after the record is filed based on the date entered.

2. Reason for Inactivation/Reactivation

File the data.

Once the data is filed, on the inactivation date set for the MCP place of care, that place of care is no longer linked to the specified provider. If the provider was a PCM in the inactivated place of care, all users are unable to assign patients to the PCM as their PCM. The specified provider no longer appears on the PCM picklists for the inactivated place of care.
In addition, all users are unable to book appointments or enter Wait List requests for the specified provider at the inactivated place of care.
Also, the specified provider no longer appears on any HCF provider search picklist (i.e., PCM booking, appointment referral booking, enrolled booking) for the inactivated place of care. If the provider is linked to other places of care; however, the provider still appears on picklists for those places of care.
The system checks for any discrepancies linked to the inactivation and prompts you to generate a Discrepancy Avoidance Report if any discrepancies are found. Refer to Figure 2-102. Reminder to Run the Discrepancy Avoidance Report, page 2-217.

```
UPTOWN MEDICAL CLINIC will be inactivated on 06 Aug 1997 !!

                     DISCREPANCY AVOIDANCE REPORT

,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,

                     This may be a COMPLEX report.
                        Please queue it to print
               during the night or other non-peak hours.
         Printing it NOW may impact other users on the system.

,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Do you want to proceed with this report? No//
```

Figure 2-102. Reminder to Run the Discrepancy Avoidance Report

The Discrepancy Avoidance Report lists any pending appointments/wait list requests or PCM assignments for the provider linked to the inactivated place of care. The discrepancies identified must be resolved for the specified provider and place of care. Refer to Figure 2-135. Discrepancy Avoidance Report, page 2-281.

Queue the report to run during non-peak hours.

The system redisplays the Provider Group Inactivate/Reactivate Maintenance screen. Refer to Figure

2-98. Provider Group Inactivate/Reactivate Maintenance Screen with Inactivation Action Bar, page 2-215.
Exit the option

Note: You may reactivate a place of care by accessing the Inactivation/Reactivation of Place of Care screen. Refer to Figure 2-101. Inactivation/Reactivation of Place of Care Screen, page 2-216. Press <Return> until the cursor reaches the Reactivation Date field, then enter the appropriate reactivation date.

The system also generates a mail bulletin (refer to Figure 2-103. Inactivated Place of Care Bulletin, page 2-219) to the CPZMGR mail group when the inactivation is to become effective. The bulletin also reminds mail group members to generate the Discrepancy Avoidance Report. Refer to Figure 2-135. Discrepancy Avoidance Report, page 2-281. The discrepancies identified must be resolved for the provider's inactivated place of care.

```
Subj: Inactivated Place of Care  Wed, 06 Aug 1997 14:56:25  18 Lines
From: POSTMASTER (Sender: SHIPMAN,JANE) in 'IN' basket.  **NEW**
,,,,,,,,,,,,,,,,,,,,,,,,Expires: 10Aug1997,,,,,,,,,,,,,,,,,,,,,,,,
The following Place of Care will be inactivated:

         Place of Care: UPTOWN MEDICAL CLINIC
     Inactivation date: 06 Aug 1997
     Reactivation date:

Reason for Inactivation/Reactivation:
     Dr. Underhill no longer practices at the Uptown Medical Clinic.

------------------------------------------------------------------------
  Groups
     Providers
------------------------------------------------------------------------
  UPTOWN MEDICAL CARE
     UNDERHILL,GEORGIA

REMINDER:
Print the Discrepancy Avoidance Report to check for any discrepancies.

Select MESSAGE Action: IGNORE (in IN basket)//
```

Figure 2-103. Inactivated Place of Care Bulletin

Inactivate/Reactivate an MCP place of care for one provider group

Access the GNET option

Access the Provider Group Profile/Agreement Maintenance screen

Complete the inactivation/reactivation action

File the data

Queue the report to run during non-peak hours

Exit the option

Access the GNET option

Access the Provider Group Profile/Agreement Maintenance screen

Refer to Figure 2-97. Provider Group Profile/Agreement Maintenance Screen with Inactivate/Reactivate Action Bar, page 2-214.

Enter I to select the (I)nactivate/Reactivate action.

Enter G to select the (G)roup Place of Care action.

The system displays the Place of Care Inactivation/Reactivation in One Group screen where you

can select the specific place of care you wish to inactivate/reactivate. Refer to Figure 2-104. Place of Care Inactivation/Reactivation In One Group Screen, page 2-220.

Complete the inactivation/reactivation action

```
        PLACE OF CARE INACTIVATION/REACTIVATION IN ONE GROUP


Provider Group: SUBURBAN MEDICAL GROUP
------------------------------------------------------------------------
  Place of Care
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
...DOWNTOWN MEDICAL CLINIC
...SUBURBAN MEDICAL CLINIC
...UPTOWN MEDICAL CLINIC



,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Use SELECT key to select Place of Care to inactivate/reactivate or
Press <RETURN> to continue
```

Figure 2-104. Place of Care Inactivation/Reactivation In One Group Screen

1. Position the cursor beside the place of care you wish to inactivate and press <Select>.

The system displays the Inactivation/Reactivation of Place of Care screen where you can enter either an inactivation date or a reactivation date. Refer to Figure 2-101. Inactivation/Reactivation of Place of Care Screen, page 2-216.

2. Inactivation Date

You may enter a past date, today's date, or a date in the future. On the inactivation date entered, the place of care inactivation for the selected provider becomes effective immediately after the record is filed based on the date entered.

3. Reason

File the data

Once the data is filed, on the inactivation date set for the MCP place of care, that place of care is no longer linked to the specified provider group and for all providers who practiced there. If any providers in the specified provider group were PCMs in the inactivated place of care, all users are unable to make PCM assignments for this providers at that place of care. None of the providers linked to the inactivated place of care appear on the PCM picklists for the inactivated place of care.

In addition, all users are unable to book appointments through either PCM or appointment referral booking or enter Wait List requests for any providers at the inactivated place of care.

The system checks for any discrepancies linked to the inactivation and prompts you to generate a Discrepancy Avoidance Report if any discrepancies are found. Refer to Figure 2-102. Reminder to Run the Discrepancy Avoidance Report, page 2-217.

The Discrepancy Avoidance Report lists any pending appointments/wait list requests or PCM assignments for providers linked to the inactivated place of care. The discrepancies identified must be resolved for the specified place of care. Refer to Figure 2-135. Discrepancy Avoidance Report, page 2-281.

Queue the report to run during non-peak hours.

The system redisplays the Provider Group Inactivate/Reactivate Maintenance screen. Refer to Figure 2-98. Provider Group Inactivate/Reactivate Maintenance Screen with Inactivation Action Bar, page 2-215.

Exit the option

Note: You can reactivate a place of care by accessing the Inactivation/Reactivation of Place of Care screen. Refer to Figure 2-101. Inactivation/Reactivation of Place of Care Screen, page 2-216. Press <Return> until the cursor reaches the Reactivation Date field and then enter the appropriate reactivation date.

The system also generates a mail bulletin (refer to Figure 2-105. Inactivated Place of Care Bulletin, page 2-222) to the CPZMGR mail group when the inactivation is to become effective. The bulletin also reminds mail group members to generate the Discrepancy Avoidance Report. Refer to Figure 2-135. Discrepancy Avoidance Report, page 2-281. The discrepancies identified must be resolved for the inactivated provider group place of care.

```
Subj: Inactivated Place of Care  Wed, 06 Aug 1997 14:56:25  18 Lines
From: POSTMASTER (Sender: SHIPMAN,JANE) in 'IN' basket.  **NEW**
,,,,,,,,,,,,,,,,,,,,Expires: 10 Aug 1997,,,,,,,,,,,,,,,,,,,,,,,,_
The following Place of Care will be inactivated:

         Place of Care: UPTOWN MEDICAL CLINIC
     Inactivation date: 06 Aug 1997
     Reactivation date:

Reason for Inactivation/Reactivation:
     Closed for renovation.
```

```
------------------------------------------------------------------------
  Groups
     Providers
------------------------------------------------------------------------
  SUBURBAN MEDICAL GROUP
     FREEMAN,GEORGE
     UPTOWN MEDICAL CLINIC
     UNDERHILL,GEORGIA

REMINDER:
Print the Discrepancy Avoidance Report to check for any discrepancies.

Select MESSAGE Action: IGNORE (in IN basket)//
```

Figure 2-105. Inactivated Place of Care Bulletin

Inactivate/Reactivate an MCP place of care for one provider

Note: To inactivate/reactivate an MCP Provider in **ALL** Provider Groups, use **Menu Path:** CA → M → FMCP → PTAB → PROV

Refer to Section 2.1.3.3 **Provider Enter/Edit (PROV)**, page 2-128.

Access the GNET option

Access the Provider Group Profile/Agreement Maintenance screen

Complete the inactivation/reactivation action

File to data

Queue the report to run during non-peak hours

Exit the option

Access the GNET option

Access the Provider Group Profile/Agreement Maintenance screen

Refer to Figure 2-97. Provider Group Profile/Agreement Maintenance Screen with Inactivate/Reactivate Action Bar, page 2-214.

Enter I to select the (I)nactivate/Reactivate action.

Enter I to select the (I)nactivate Provider action.

The system displays an alphabetical list of the providers linked to the specified provider group. Refer to Figure 2-106. Individual Provider Profile, page 2-224.

Complete the inactivation/reactivation action

```
INDIVIDUAL PROVIDER PROFILE
```

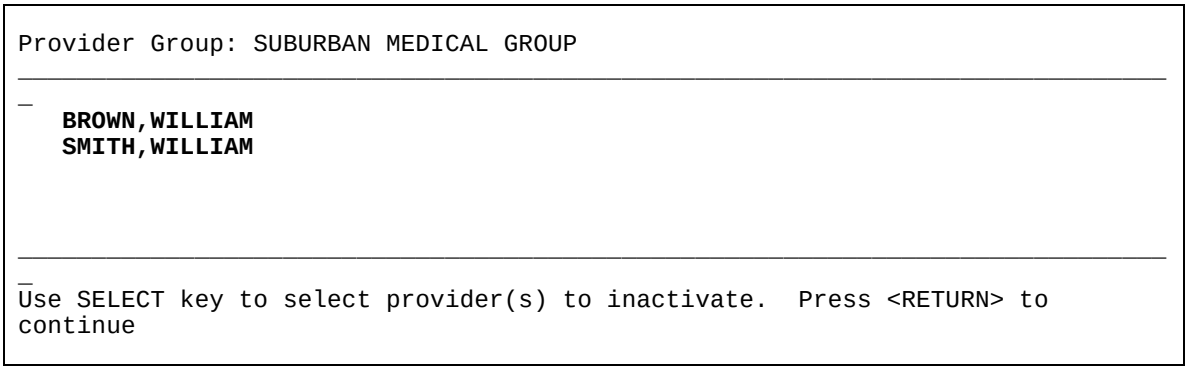


Figure 2-106. Individual Provider Profile

Select the MCP provider to inactivate.

Use the arrow keys to position the cursor beside the provider name, press <Select>, then press <Return>. The system displays the Provider Inactivation from a Group screen. Refer to Figure 2-107. Provider Inactivation From a Group Screen, page 2-224.

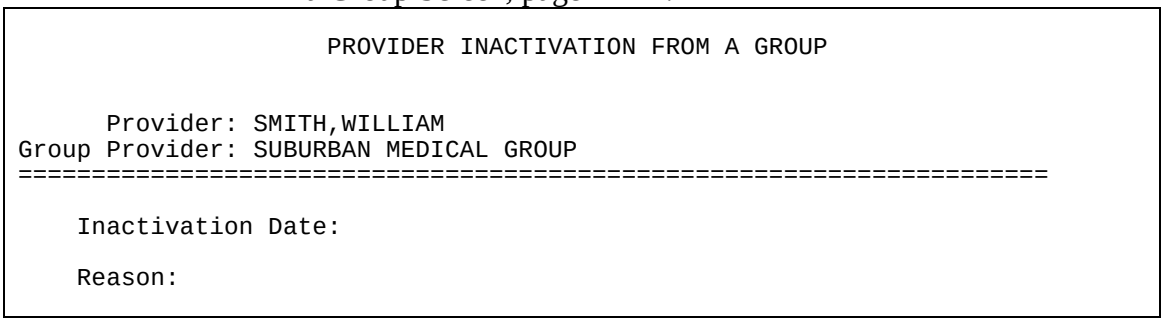


Figure 2-107. Provider Inactivation From a Group Screen

1. Inactivation Date

You may enter a past date, today's date, or a date in the future. On the inactivation date entered, the provider inactivation becomes effective immediately after the record is filed based on the date entered.

Once the inactivation becomes effective users cannot book MCP appointments, enter Wait List requests, or assign patients to the specified provider as their PCM. The provider no longer appears on any provider picklists for any place of care linked to the MCP provider group from which the provider was inactivated.

2. Reason

File the data

The system checks for any discrepancies linked to the inactivation and prompts you to generate a Discrepancy Avoidance Report if any discrepancies are found. Refer to Figure 2-102. Reminder to Run the Discrepancy Avoidance Report, page 2-217.

The Discrepancy Avoidance Report lists any pending appointments/Wait List requests or PCM assignments for the inactivated provider linked to the inactivation. The discrepancies identified must be resolved for the specified provider. Refer to Figure 2-135. Discrepancy Avoidance Report, page 2-281.

Queue the report to run during non-peak hours.

The system returns to the Provider Group Inactivate/Reactivate Maintenance screen. Refer to Figure 2-98. Provider Group Inactivate/Reactivate Maintenance Screen with Inactivation Action Bar, page 2-215, with additional action, (R)eactivate Provider.

Exit the option

Note: You may reactivate a provider by selecting the (R)eactivate Provider from the Inactivation/Reactivation action bar. Refer to Figure 2-98. Provider Group Inactivate/Reactivate Maintenance Screen with Inactivation Action Bar, page 2-215. The system then displays the same Provider Inactivation from a Group screen (refer to Figure 2-107. Provider Inactivation From a Group Screen, page 2-224) where you can delete the inactivation date for the specified provider.

The system also generates a mail bulletin (refer to Figure 2-108. Inactivation/Reactivation Bulletin, page 2-226) to the CPZMGR mail group when the inactivation is to become effective. The bulletin also reminds mail group members to generate the Discrepancy Avoidance Report. Refer to Figure 2-135. Discrepancy Avoidance Report, page 2-281. The discrepancies identified must be resolved for the inactivated provider.

```
Subj: Inactivated Provider  Mon, 04 Aug 1997 11:00:17  19 Lines
From: POSTMASTER (Sender: RUSSELL,ANN (Postmaster) in 'IN' basket.
**NEW**
,,,,,,,,,,,,,,,,,,,,,,,,Expires: 04 Sep 1997,,,,,,,,,,,,,,,,,,,,,,

  Provider SMITH,WILLIAM will be inactivated on 04 Aug 1997 !!


Reason for Inactivation/Reactivation:
     Provider has moved from this area.

  Provider: SMITH,WILLIAM
-------------------------------------------------------------------------
  Group
     Places of Care
-------------------------------------------------------------------------
  SUBURBAN MEDICAL GROUP
     SUBURBAN MEDICAL CLINIC

REMINDER:
     Print the Discrepancy Avoidance Report to check for any
discrepancies.


Select MESSAGE Action: IGNORE (in IN basket)//
```

Figure 2-108. Inactivation/Reactivation Bulletin

- **Functionality Interactions**

None

- **Troubleshooting**

Inactivated entries remain visible when accessing groups and places of care. They appear dimmed and should not interfere in the normal processes.

2.2.1.5 PCM Activation

Menu Path: Refer to the path specified for each of the four PCM flags.

- **Security Keys**

CPZ CCP
CPZ FILE
CPZ AGREEMENT
CPZ LOWCAP
CPZ NET

- **Required Fields**

Activate Provider Group
Refer to Figure 2-109. GRP PRO1 – Provider Group Profile, page 2-229.
Specialty(s)

Refer to Figure 2-110. Individual Provider Profile, IND PL1 Screen, page 2-230.
PCM
Refer to Figure 2-110. Individual Provider Profile, IND PL1 Screen, page 2-230.
Activate Group PCM
Refer to Figure 2-112. Provider Group PCM Capacities, page 2-232.
PCM
Refer to Figure 2-113. Individual Provider PCM Capacity Screen, page 2-233.

- **Application Description**

Designating an individual provider or a group provider as a PCM is done through this menu option and may be done as the group is built or afterwards. This section is presented separately to provide as little confusion as possible. **There are four flags to set to YES when designating PCMs**; however, not all of them are required to be set to YES.

- **Business Rules**

– PCMs must be defined before any enrollments/empanelments can start.
– PCMs must be defined before establishing UIC/PCM links.
– PCMs must be defined as network provider types.
– If the individual PCMs work at more than one place of care within a group, enrolled patients may only be seen at one place of care.
– If the group provider does not have a schedule, and all individual providers in the group are PCMs, all schedules for all providers display in PCM booking.
– If the group provider does not have a schedule, and only some individual providers in the group are PCMs, only the schedules for the PCMs in the group display.
– If the patient's PCM is an individual provider, only that provider's schedule display.

- **Other Important Considerations**

The MTF must decide before hand whether groups will be PCMs. If so, will some or all providers be PCMs? Schedules display according to who are designated as PCMs and whether the group provider has a schedule.
If a group has multiple places of care and a provider acting as a PCM works at more than one location, the MTF must decide which place of care to send the enrollees to and enroll them to that place of care.

- **Data Entry Process**

Create PCMs

Menu Path: PAS System Menu → M → PMCP → GNET → Provider Group → Activate Group Provider: **YES**

Access the GNET option

Create the group provider as a PCM

File the data

Create the group PCM specialties

Create the PCM agreement types

Create the individual PCM providers

Group provider as a PCM

Access the GNET option

Create the group provider as a PCM

Enter the group name at the *Provider Group* prompt. The GRP PRO1 – Provider Group Profile screen displays. This screen allows the user to define demographic and place of care information. Refer to Figure 2-109. GRP PRO1 – Provider Group Profile screen, page 2-229.

```
  MCP PROVIDER GROUP: ACUTE CR MTF                                        GRP
PRO1

                            PROVIDER GROUP PROFILE

 ============================================================================
          Short Group ID: ACCM
                 Tax ID#:
          CHAMPUS Number:
           Provider Type: NETWORK PROVIDER GROUP
 Activate Group Provider: YES

 Payment Address 1: 6625 16th Street
 Payment Address 2:
       Payment Zip: 20307
      Payment City: WASHINGTON
     Payment State: DISTRICT OF COL
     Payment Phone: 202 427-1201       Payment Contact: Billing Officer

  Places of Care:
  ACUTE CR MTF


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 2-109. GRP PRO1 – Provider Group Profile Screen

1. Activate Group Provider

Set to YES to make the group a PCM. **This is the first flag to set**. Use the down-arrow key to move down the screen and bypass the Place of Care field.

File the data

The Provider Group Profile/Agreement Maintenance screen displays.

Create the group PCM specialties

Menu Path: PAS System Menu → M → PMCP → GNET → Provider Group → Bypass Place of care → (P)roviders → (E)dit → Select Group

Select (P)roviders from the action bar and access the Individual Provider Profile. The name of the group now displays among the individual providers because of the first flag set.

Select (E)dit from the action bar and select the group provider. The system then accesses the IND PROF – Group Provider Profile screen. This screen displays defaulted information from the group profile such as address and the Place(s) of Care. Press <Return> until the system access the next screen. Do not press <Do> or <Next Screen> to access the IND PL1 – Individual Provider Profile screen. Refer to Figure 2-110. Individual Provider Profile, IND PL1 Screen, page 2-230.

```
 PLACE OF CARE: ACUTE CR MTF                    IND PL1

                       INDIVIDUAL PROVIDER PROFILE

       Provider: ACUTE CR MTF
  Place of Care: ACUTE CR MTF
 Provider Group: ACUTE CR MTF
=========================================================================
  Specialty(s)                                                  PCM
-------------------------------------------------------------------------
  FAMILY PRACTICE PHYSICIAN                                     YES
  FAMILY PRACTICE/PRIMARY CARE                                  NO
  PRIMARY CARE NURSE PRACTITIONER QUALIFIED                     NO




                              Position cursor next to the last entry and
                     Press the Down Arrow key to exit.
```

Figure 2-110. Individual Provider Profile, IND PL1

Screen

1. The IND PL1 screen displays all specialties represented by the individual providers in the group. To the right of the Specialties displayed is the PCM field with all entries set to NO initially. Set the PCM field to YES for each provider specialty linked to the group provider. **This is the second flag to set**.
2. Position the cursor next to the desired specialty and press <Return> to reach the PCM field. After the desired specialties have been activated, exit this screen using the down-arrow key.
3. Next, you receive a prompt to enter PAS profile information on the group provider and then appointment types. If you answer "YES," the system displays a new action bar:

Select (A)ctive, (I)nactive appointment types, or (Q)uit: A//

4. Press <Return> to accept the (A)ctive action and display the CP NET HCP Profile screen. Refer to Figure 2-111. CP NET HCP Profile Screen, page 2-231.

```
PROVIDER: ACUTE CR MTF   CP NET HCP PROFILE - CONTINUATION - CONTINUATION

 PROVIDER: ACUTE CR MTF
 CLINIC HOURS:
 LOCATION:
 MAX # OF PATIENT APPTS PER DAY:  100
 APPT ARRIVAL ADVANCE TIME:    minutes
 PROVIDER INSTRUCTIONS:
 PRINT ROSTER WITH OPEN APPTS:  YES, print rosters with open appts
 INACTIVATION DATE:
```

Figure 2-111. CP NET HCP Profile Screen

1. When completed, you receive prompts to accept the appointment types from the place of care. When completed and filed, you return to the IND PROF screen. The cursor in this screen is positioned at the place of care. If you press <Return>, you return to the specialty screen. Use the down-arrow key to file the data.
2. Repeat this process for each place of care linked to the group provider.

Create the PCM agreement types

Menu Path: PAS System Menu → M → PMCP → GNET → Provider Group → Bypass Place of care → (A)greements → Enrollment (M)ix → Select Agreement Type → Activate Group PCM: YES

```
                          PROVIDER GROUP PCM CAPACITY

     Provider Group: ACUTE CR MTF
     Agreement Type: MTF - MTF STAFF
 Dates of Agreement: 01 Jan 2001 - 01 Jan 2005
 Activate Group PCM: YES

 Maximum Patient Capacity:500        Age Range to Apply Overall:     -
           Total Assigned:15
================================================================================
=
                                                                 Total     Pat Out of
 Enrollment Mix                     Age Range   Capacity   Assigned   Age Range
--------------------------------------------------------------------------------
-
  ACTIVE DUTY                           -       250        11
  ACTIVE DUTY FAMILY MEMBER             -       250        4
  RETIREE                               -       0
  RETIREE FAMILY MEMBER                 -       0
  MEDICARE                              -
  OTHER                                 -



 Help = HELP      Exit = F10     File/Exit = DO                      INSERT OFF
```

Figure 2-112. Provider Group PCM Capacities

1. After you select and access the desired agreement type to set the flag, the cursor is positioned at the Activate Group PCM field. Set this to YES to activate the group agreement. **This is the 3rd flag to set**.
2. You may also set capacities for this agreement if not done so yet.

Create the individual PCM providers

Menu Path: PAS System Menu → M → PMCP → GNET → Provider Group → Bypass Place of care → (P)roviders → Agreement E(X)ceptions → Select provider → Enrollment (M)ix → Select Agreement Type → PCM: **YES**

This screen allows you to define an individual provider as a PCM and establish enrollment capacities.

```
                          INDIVIDUAL PROVIDER PCM CAPACITY

           Provider: ENRIQUEZ,FRANK M
     Provider Group: ACUTE CR MTF
     Agreement Type: MTF - MTF STAFF
 Dates of Agreement: 01 Jan 2001 - 01 Jan 2005
                PCM: YES

 Maximum Patient Capacity: 500     Age Range to Apply Overall:     -
           Total Assigned: 1
================================================================================
=
                                                                  Total     Pat Out of
 Enrollment Mix                     Age Range   Capacity   Assigned   Age Range
--------------------------------------------------------------------------------
-
  ACTIVE DUTY                           -       250        1
  ACTIVE DUTY FAMILY MEMBER             -       250
  RETIREE                               -
  RETIREE FAMILY MEMBER                 -
  MEDICARE                              -
  OTHER                                 -



 Help = HELP      Exit = F10     File/Exit = DO                      INSERT OFF
```

Figure 2-113. Individual Provider PCM Capacity Screen

1. To set up an individual Provider as a PCM, access the (P)roviders, then the Agreement e(X)ceptions, and finally Enrollment (M)ix. Select the agreement type this provider will participate in as a PCM and set the field PCM to YES. **This is the 4th flag to set**.
2. If all providers within the group are PCMs, you do not need to set the individual provider PCM flags. The system assumes that all providers in the group are PCMs.

- **Functional Interactions**

None

- **Troubleshooting**

Most problems occur when the wrong flag is set or not enough are set. If you cannot access the PCM or specialty you desire, review all flags to ensure they are set correctly. The most commonly forgotten flag is the specialty. Review your MTF policy as to whom or what the PCMs will be and adjust your groups as necessary.

2.2.2 Individual Provider Profile/Agreements Enter/Edit (INET)

Menu Path: PAS System Menu → M → PMCP → INET

- **Security Keys**

CPZ CCP
CPZ FILE

CPZ AGREEMENT
CPZ LOWCAP
CPZ NET

- **Required Fields**

The required fields are the same as those in GNET.

- **Application Description**

The Individual Provider Profile/Agreements Enter/Edit (INET) option allows you to enter or edit individual provider profile and agreement data for selected MCP providers. In addition, you can inactivate or reactivate MCP providers or the providers' places of care. A provider can also be added as a new member to an existing MCP provider group. While adding or editing places of care, you can use the Provider Profile Enter/Edit option to update provider profiles, since no appointments can be booked for the provider until PAS provider profile information is entered.

- **Business Rules**

Refer to Section 2.2.1 Group Profile/agreements Enter Edit (GNET), page 2-161, Business Rules.

- **Other Important Considerations**

Any action taken through this menu option may also be done through the Group Profile/Agreements Enter/Edit (GNET) option.

- **Data Entry Process**

Add a new member to an existing MCP provider group

Access the INET option

Enter the provider name

Select the (A)dd action on the Individual Provider Profile/Agreement Maintenance screen action bar

Enter the new Provider Group name and verify that the provider name and group name are correct

Transfer some, all, or none of the group places of care to the provider

Press <Return> through the IND PROF1 - Individual Provider Profile screen

Press <Return> through the IND PROF3 - Individual Provider Profile screen

Press <Return> through the IND PROF4 - Individual Provider Profile screen

Select the provider's place(s) of care on the IND PROF5 - Individual Provider Profile screen

Press <Return> at the provider's specialty on the IND PL1 - Individual Provider Profile screen

Enter hours of service on the IND PL2 - Individual Provider Profile screen

Enter procedures offered by the provider at this place of care

Enter PAS profile information

Enter Active appointment types

Complete the CP NET HCP PROFILE - Continuation - Continuation screen

Answer all prompts for each appointment type displayed

Access the INET option
The system displays the Individual Provider Profile/Agreement Maintenance screen.

```
               INDIVIDUAL PROVIDER PROFILE/AGREEMENT MAINTENANCE

      Provider:
Provider Group:
------------------------------------------------------------------------


------------------------------------------------------------------------
Select Provider:
```

Figure 2-114. Individual Provider Profile/Agreement Maintenance Screen

Enter the provider name
After you enter and verify the provider name, the system replaces the *Select Provider* prompt with this action bar:
Would you like to (A)dd '[PROVIDER NAME]' to a new group, (C)ontinue to process as a member of [GROUP NAME]' or (Q)uit: C//

Select the (A)dd action on the Individual Provider Profile/Agreement Maintenance screen action bar
The system replaces the action bar with the *Select new Provider Group* prompt.

Enter the new provider group name and verify that the provider and group names are correct
The system asks if you want to transfer all group places of care to this provider. The default is "NO." If the provider does not work at all places of care for this provider group, accept the "NO" default.

Transfer some, all, or none of the group places of care to the provider

When you accept the "NO" default at the previous prompt, the system prompts you, one by one, to indicate which of the group places of care to transfer to this provider. Press <Return> to accept the "YES" default for each place of care where the provider works. Otherwise, enter "N" for NO.

When you have responded to the last prompt to transfer places of care, the system displays the IND PROF1 - Individual Provider Profile screen. Refer to Figure 2-83. IND PROF1 - Individual Provider Profile Screen, page 2-195.

Press <Return> through the IND PROF1 - Individual Provider Profile screen

Refer to Figure 2-83. IND PROF1 - Individual Provider Profile Screen, page 2-195.

Press <Return> to exit the Language field. The system displays the IND PROF3 - Individual Provider Profile screen.

Press <Return> through the IND PROF3 - Individual Provider Profile screen

Refer to Figure 2-84. IND PROF3 - Individual Provider Profile Screen, page 2-197.

Press <Return> at the Professional Category field. The system displays the IND PROF4 - Individual Provider Profile screen.

Press <Return> through the IND PROF4 - Individual Provider Profile screen

Refer to Figure 2-85. IND PROF4 - Individual Provider Profile Screen, page 2-198.

Press <Return> at the Payment Contact field. The system displays the IND PROF5 - Individual Provider Profile screen. Refer to Figure 2-86. IND PROF5 - Individual Provider Profile Screen, page 2-199.

Select the provider's place(s) of care on the IND PROF5 - Individual Provider Profile screen

Refer to Figure 2-86. IND PROF5 - Individual Provider Profile Screen, page 2-199.

Press <Return> at the provider's place of care. The system displays the Individual Provider Profile - IND PLI screen. Refer to Figure 2-87. IND PL1 - Individual Provider Profile (Place of Care) Screen, page 2-200.

Press <Return> at the provider's specialty on the IND PL1 - Individual Provider Profile screen

Press <Return>, the system displays the IND PL2 - Individual Provider Profile screen. Refer to, Figure 2-88. IND PL2 - Individual Provider Profile (Place of Care) Screen page 2-201.

Enter hours of service on the Individual Provider Profile - IND PL2 screen

Refer to Figure 2-88. IND PL2 - Individual Provider Profile (Place of Care) Screen, page 2-201.

Press <Return> to exit this screen. The system displays the Individual Provider Services Offered Profile screen. Refer to Figure 2-89. Individual Provider Services Offered Profile Screen, page 2-202.

Enter procedures offered by the provider at this place of care

Refer to Figure 2-89. Individual Provider Services Offered Profile Screen, page 2-202.

At the Individual Provider Services Offered Profile screen, you can choose to add procedures as a block or singly, view procedures, delete procedures, or quit.

Enter PAS Profile information

When you finish entering procedures, the system asks if you want to enter/edit the provider's PAS profile information. If you enter "N" for NO, the following message is displayed:

```
**WARNING** No appointments can be booked for this Provider until PAS
Provider Profile information is entered!
Press <RETURN> to continue
```

If you accept the YES default, the system displays the following action bar:

Select (A)ctive, (I)nactive appointment types, or (Q)uit: A//

Enter Active appointment types

When you accept the (A)ctive default, the system displays the CP NET HCP Profile screen. Refer to Figure 2-90. CP NET HCP Profile - Continuation - Continuation Screen, page 2-203.

Complete the CP NET HCP Profile - Continuation - Continuation screen

Refer to Figure 2-90. CP NET HCP Profile - Continuation - Continuation Screen, page 2-203.

Answer all prompts for each appointment type displayed

For each place of care, you may enter/edit the Specialty(s) and Hours of Service fields, then process CPT-4 codes to indicate the procedures offered by the provider.

If you accept the (C)ontinue default at the *Would you like to (A)dd '[PROVIDER NAME]' to a new group,(C)ontinue to process as a member of [GROUP NAME]'or (Q)uit: C//* prompt, you proceed to the Individual Provider Profile Agreement Maintenance screen displayed in GNET. Refer to Figure 2-115. Individual Provider Profile/Agreement Maintenance Screen, page 2-240.

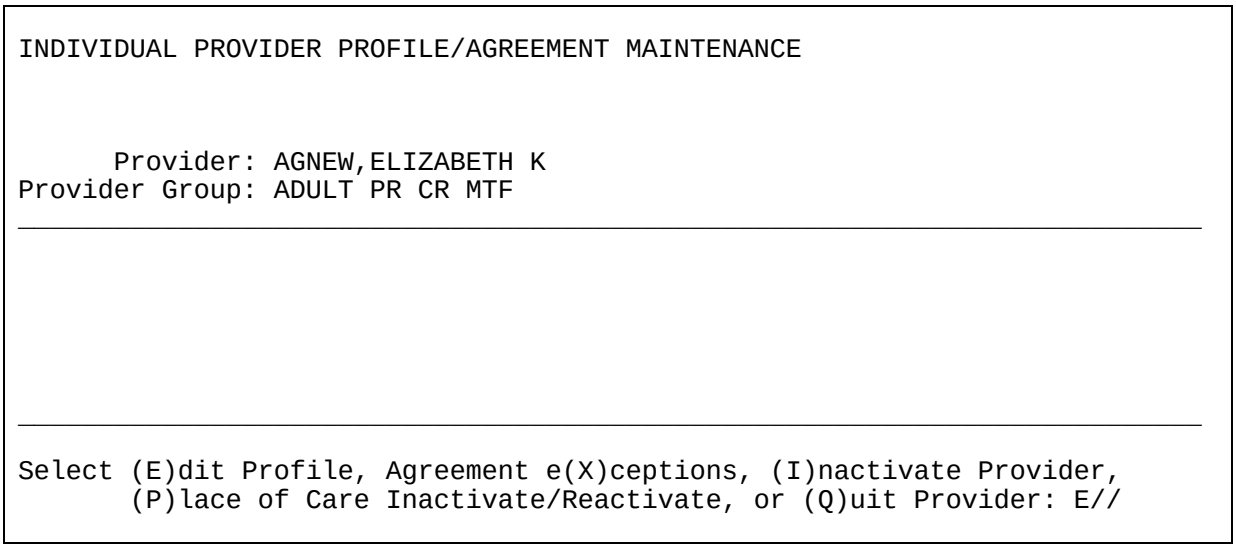


Figure 2-115. Individual Provider Profile/Agreement Maintenance Screen

Select (E)dit profile, Agreement e(X)ceptions, (I)nactive Provider, (P)lace of Care Inactivate/Reactivate, or (Q)uit Provider:

- (E)dit - Allows you to edit the individual provider's MCP Profile.
- Agreement e(X)ceptions - Allows you to edit the agreements for this provider. Refer to Section 2.2.1.3 GNET – Providers, page 2-190, Data Entry Process.
- (I)nactivate Provider - Allows you to inactivate an individual. Refer to Section 2.2.1.4 GNET – Inactivation/Reactivation, page 2-210.
- (P)lace of Care Inactivate/Reactivate - Allows you to inactivate a provider from a place of care. Refer to Section 2.2.1.4 GNET – Inactivation/Reactivation, page 2-210.
- (Q)uit - Allows you to quit and exit.

Note: The individual provider profile can be edited using either the Group Profile/Agreements Enter/Edit (GNET) option or the Individual Provider Profile/Agreements Enter/Edit (INET) option. The INET option is not used to create a new provider profile. It can, however, be used to add a provider to a group. The provider's specialties and languages, gender, military rank, military status, and professional category should be entered using the Provider Enter/Edit option on the Provider Network File/Table Maintenance Menu. Use the INET option, instead of GNET, when updating an individual provider's profile.

- **Functionality Interactions**

None

- **Troubleshooting**

Refer to Section 2.2.1 Group Profile/agreements Enter Edit (GNET), page 2-161, Troubleshooting.

2.2.3 Modify Group Agreement Effective Date (MNET)

Menu Path: PAS System Menu → M → PMCP → MNET

- **Application Description**

The Modify Group Agreement Effective Date (MNET) option allows you to modify the effective date of an agreement for a provider group. Each modification causes the system to produce an agreement history record; these records are numbered and sorted in chronological order. This option also allows you to view the agreement history records.

- **Data Entry Process**

Overview

The system enables you to proceed through the Managed Care Program Menu to the Provider Network Management Menu and select the Modify Group Agreement Effective Date option.

Action Bar: (S)earch Criteria, (V)iew Agreement History, or (Q)uit

The system prompts you to begin by selecting an action from the main action bar. This action bar enables you to select either to specify search criteria for an agreement search, to view an agreement history record, to enter a new effective date for the current provider group agreement, or to quit the option.

Main Action Bar, Search Criteria

The system displays such search criteria as group and agreement type. The system prompts you to select the criteria to enter. The group and agreement type criteria are mandatory. The system then prompts you to enter data for each of the criteria selected.

Then the system lists all agreements meeting the search criteria, and prompts you to select the agreement you desire.

Then the system returns to the action bar described under "Main Action Bar."

Main Action Bar, View Agreement History

The system displays a list of the agreements for the group and prompts the user to select the agreement history record to view.

Then the system displays the MCP View Modified Agreements screen. This screen displays data such as provider group, agreement type, agreement original start date, agreement amended start date, agreement original stop date, PCM count, referral count, discount rate, fee base, PCM status, and original date FI notified.

When you are finished with this screen, the system returns to the action bar described under "Main Action Bar."

Main Action Bar, New Agreement Effective Date

The system prompts you to accept the default effective date already on record for the selected agreement or to enter a new agreement effective date. The system then allows you to proceed with the change or to exit the action. If you elect to proceed, the system automatically generates a mail message as notification of the change. The system then returns to the action bar described under "Main Action Bar."

Main Action Bar, Quit

The system allows you to select quit at the main action bar to exit the option.

2.2.4 Outputs and Network Management Reports Menu (ONET)

Menu Path: PAS System Menu → M → PMCP → ONET

Refer to Figure 2-116. Outputs and Network Management Menu (ONET), page 2-243 and Sections 2.2.4.1, 2.2.4.2 and 2.2.4.3.

```
   GMRM   Group Management Reports Menu
   AMRM   Agreement Reports Menu
   MMRM   Miscellaneous Network Reports Menu

Select Outputs & Network Management Reports Menu Option:
```

Figure 2-116. Outputs and Network Management Menu (ONET)

2.2.4.1 Group Management Reports Menu (GMRM)

Menu Path: PAS System Menu → M → PMCP → ONET → GMRM

Refer to Figure 2-117. Group Managements Reports Menu (GMRM), page 2-243, and Sections 2.2.4.1.1-5.

```
   1      Group Member Roster
   2      Provider Group Report
   3      Provider List by Specialty
   4      PCM Enrollment Mix Discrepancy Statistical Summary
   5      PCM Enrollment Mix Discrepancy Report

Select Group Management Reports Menu Option:
```

Figure 2-117. Group Managements Reports Menu (GMRM)

2.2.4.1.1 Group Member Roster

Menu Path: PAS System Menu → M → PMCP → ONET → GMRM → 1

- **Security Keys**

CPZ CCP
CPZ NET
CPZ FILE

- **Contents**

The Group Member Roster option allows you to print a roster listing TRICARE provider groups, TRICARE providers within groups, and specialties and agreements pertaining to the providers. You can selectively generate the roster for one, multiple, or all provider groups.

- **Use/Frequency**

As needed.

- **Report Sample**

Refer to Figure 2-118. Group Member Roster, page 2-246.

```
WALTER REED AMC                                    21 Jun 2001@1422    Page
1
                Personal Data - Privacy Act of 1974 (PL 93-579)
                              GROUP MEMBER ROSTER
                                  ACUTE CR MTF
GROUP DMIS ID(S): 6015                          GROUP TAX ID:
================================================================================
=
Provider Name                    UPIN         Tax ID           DMIS ID
    Specialty
    Agreement Type                                    Effective Dates      Disc %
================================================================================
=
ALCALA,GILBERT M                 ALCAGM                        6015
    FAMILY PRACTICE PHYSICIAN
    CON - CONTRACT                                    01Jan01-01Jan05      CA-60%
    MTF - MTF STAFF                                   01Jan01-01Jan05      MTF

AUSTIN,GILBERT M                 AUSTGM                        6015
    FAMILY PRACTICE PHYSICIAN
    MTF - MTF STAFF                                   01Jan01-01Jan05      MTF
    PIC - PARTNER INTERNAL                            01Jan01-01Jan05      CA-40%

BATES,SHARON M                   BATESM                        6015
    FAMILY PRACTICE PHYSICIAN
    MTF - MTF STAFF                                   01Jan01-01Jan05      MTF

CARBONARA,KYLE M                 CARBKM                        6015
    PRIMARY CARE NURSE PRACTITIONER QUALIFIED
    MTF - MTF STAFF                                   01Jan01-01Jan05      MTF

DANSON,ALICE M                   DANSAM                        6015
    FAMILY PRACTICE PHYSICIAN
    MTF - MTF STAFF                                   01Jan01-01Jan05      MTF

ENRIQUEZ,FRANK M                 ENRIFM                        6015
    PRIMARY CARE NURSE PRACTITIONER QUALIFIED
    MTF - MTF STAFF                                   01Jan01-01Jan05      MTF

FINTO,LUISA M                    FINTLM                        6015
    FAMILY PRACTICE/PRIMARY CARE
    MTF - MTF STAFF                                   01Jan01-01Jan05      MTF

GABRIEL,JOHN M                   GABRJM                        6015
    FAMILY PRACTICE/PRIMARY CARE
    MTF - MTF STAFF                                   01Jan01-01Jan05      MTF

PONY,ALAN O                      34634                         6015
    FAMILY PRACTICE PHYSICIAN
    CON - CONTRACT                                    01Jan01-01Jan05      CA-60%

PUNTA,ARLENE P                   83274                         6015
    FAMILY PRACTICE PHYSICIAN
    PIC - PARTNER INTERNAL                            01Jan01-01Jan05      CA-40%
```

Figure 2-118. Group Member Roster

2.2.4.1.2 Provider Group Report

Menu Path: PAS System Menu → M → PMCP → ONET → GMRM → 2

- **Security Keys**

CPZ CCP
CPZ NET
CPZ FILE

- **Contents**

The Provider Group Report option allows you to print a report by selected TRICARE provider group(s) and report section(s). You can select to print the report for One, Multiple, or All provider groups, and within the selected group(s), you can specify the section(s) to print.
The following sections are available for selection to be printed: group information, places of care, agreements and providers, PCMs, group level exceptions, and individual provider exceptions. Each section requested is printed on a separate page.

- **Use/Frequency**

As needed. This report should be run whenever a provider, particularly a PCM, is updated in the file and table build functions. The report should be used to validate the completeness and correctness of the total information set up for the provider. This report should be used to verify that:

– All places of care have been set up and are activated
– Places of care are not duplicated
– Groups and their members are appropriately defined and activated
– All specialties have been indicated for the provider and provider group
– Individual provider agreement start and stop dates are within the group agreement start and stop dates
– The group is designated as a PCM if any group member is a PCM
– PCM enrollment mixes/capacities are set up correctly
– PCM capabilities have been entered correctly at the group and group member levels, including definition of the correct places of care and appropriate **specialties** indicated as primary care for the provider

– The maximum PCM capacities are set up consistently for the group and for each group member
– General verification of all provider data as needed.

- **Report Sample**

Refer to:
Figure 2-119. Provider Group Report - Group Information, page 2-248.
Figure 2-120. Provider Group Report - Places of Care, page 2-249.
Figure 2-121. Provider Group Report - Agreements and Providers, page 2-251.
Figure 2-122. Provider Group Report - Primary Care Managers, page 2-252.

```
WALTER REED AMC                                    21 Jun 2001@1427   PAGE 1

                Personal Data - Privacy Act of 1974 (PL 93-579)
                            PROVIDER GROUP REPORT
                         *** Group Information ***

GROUP:  ACUTE CR MTF
================================================================================
=
           Short Group ID:  ACCM
                  Tax ID#:
              CHAMPUS Nbr:
        MCP Provider Type:  NETWORK PROVIDER GROUP


        Payment Address 1:  6625 16th Street
        Payment Address 2:
             Payment City:  WASHINGTON
            Payment State:  DC
         Payment Zip Code:  20307
            Payment Phone:  202 427-1201
          Payment Contact:  Billing Officer
```

Figure 2-119. Provider Group Report - Group Information

```
WALTER REED AMC                                    21 Jun 2001@1427   PAGE 2

               Personal Data - Privacy Act of 1974 (PL 93-579)
                           PROVIDER GROUP REPORT
                           *** Places of Care ***

GROUP:  ACUTE CR MTF  (continued)
================================================================================
=
            Place of Care:  ACUTE CR MTF
            Building Name:
          Building Number:
           Street Address:  6885 16TH STREET
                     City:  WASHINGTON
                    State:  DC
                 Zip Code:  20307
               Appt Phone:  202 271-5851
         Type of Facility:  MULTISERVICE CLINIC
                 Division:  DIV A - TRAINING HOSPITAL
               Department:  PRIMARY CARE DEPARTMENT
                  Service:  PRIMARY CARE SERVICE
               MEPRS Code:  BGAA
            Cost Pool Code:
               Clinic Type:  COUNT
             Location Type:  CLINIC
 Clinic Appt Instructions:  Arrive 10 minutes early.

Appt Type/         Workload      Referral   Pull Patient   Send
  Instructions     Type          Required   Record         Reminder
================================================================================
=
CON                COUNT            Y           Y             Y
FOL                COUNT            N           Y             Y
NEW                COUNT            Y           Y             Y
T-CON*             COUNT                        Y
```

Figure 2-120. Provider Group Report - Places of Care

```
WALTER REED AMC                                    21 Jun 2001@1427   PAGE 3

               Personal Data - Privacy Act of 1974 (PL 93-579)
                          PROVIDER GROUP REPORT
                     *** Agreements and Providers ***

GROUP:  ACUTE CR MTF  (continued)
================================================================================
                                                    Effective    Stop       Overall
Agreement  Agreement Name                             Date       Date
Discount
_________  _________ ____                           _________    ____
_________
CON        CONTRACT                                 01 Jan 01  01 Jan 05    CA- 60%
MTF        MTF STAFF                                01 Jan 01  01 Jan 05    CA-100%
PIC        PARTNER INTERNAL                         01 Jan 01  01 Jan 05    CA- 40%

GROUP INDIVIDUAL PROVIDERS
_____ __________ _________

 Provider
    Place of Care                          Specialty
    * Denotes Inactive Provider.

 ALCALA,GILBERT M
    ACUTE CR MTF                          FAMILY PRACTICE PHYSICIAN

 AUSTIN,GILBERT M
    ACUTE CR MTF                           FAMILY PRACTICE PHYSICIAN

 BATES,SHARON M
    ACUTE CR MTF                           FAMILY PRACTICE PHYSICIAN

 CARBONARA,KYLE M
    ACUTE CR MTF                           PRIMARY CARE NURSE PRACTITIONER QUALI

 DANSON,ALICE M
    ACUTE CR MTF                           FAMILY PRACTICE PHYSICIAN

 ENRIQUEZ,FRANK M
    ACUTE CR MTF                           PRIMARY CARE NURSE PRACTITIONER QUALI

 FINTO,LUISA M
    ACUTE CR MTF                           FAMILY PRACTICE/PRIMARY CARE

 GABRIEL,JOHN M
    ACUTE CR MTF                           FAMILY PRACTICE/PRIMARY CARE

 PONY,ALAN O
    ACUTE CR MTF                           FAMILY PRACTICE PHYSICIAN

 PUNTA,ARLENE P
    ACUTE CR MTF                           FAMILY PRACTICE PHYSICIAN
```

Figure 2-121. Provider Group Report - Agreements and Providers

```
WALTER REED AMC                                    21 Jun 2001@1427   PAGE 4
               Personal Data - Privacy Act of 1974 (PL 93-579)
```

```
                          PROVIDER GROUP REPORT
                      *** Primary Care Managers ***

GROUP:  ACUTE CR MTF  (continued)
================================================================================
=
Provider                    Agreement dates           Agrmt      Total    Total
  Beneficiary Cat             Age Range               Type     Capacity
Assigned
--------------------------------------------------------------------------------
-
AUSTIN,GILBERT M             -                        CON          UNL        0
  ADY ACTIVE DUTY                                                 UNL        0
  AFM ACTIVE DUTY FAMILY                                          UNL        0
  MED MEDICARE                                                    UNL        0
  OTH OTHER                                                       UNL        0
  RET RETIREE                                                     UNL        0
  RFM RETIREE FAMILY MEM                                          UNL        0
                             -                        MTF          500        0
  ADY ACTIVE DUTY                                                 500        0
  AFM ACTIVE DUTY FAMILY                                          500        0
  MED MEDICARE                                                    500        0
  OTH OTHER                                                       500        0
  RET RETIREE                                                     500        0
  RFM RETIREE FAMILY MEM                                          500        0
                             01Jan01 - 01Jan05        MTF          500        4
  ADY ACTIVE DUTY                                                 500        3
  AFM ACTIVE DUTY FAMILY                                          500        1
  OTH OTHER                                                       500        0
  MED MEDICARE                                                    500        0
  RET RETIREE                                                     500        0
  RFM RETIREE FAMILY MEM                                          500        0
BATES,SHARON M               -                        CON          UNL        0
  ADY ACTIVE DUTY                                                 UNL        0
  AFM ACTIVE DUTY FAMILY                                          UNL        0
  MED MEDICARE                                                    UNL        0
  OTH OTHER                                                       UNL        0
  RET RETIREE                                                     UNL        0
  RFM RETIREE FAMILY MEM                                          UNL        0
                             -                        MTF          500        0
  ADY ACTIVE DUTY                                                 500        0
  AFM ACTIVE DUTY FAMILY                                          500        0
  MED MEDICARE                                                    500        0
  OTH OTHER                                                       500        0
  RET RETIREE                                                     500        0
  RFM RETIREE FAMILY MEM                                          500        0
                             01Jan01 - 01Jan05        MTF          500        4
  ADY ACTIVE DUTY                                                 500        3
  AFM ACTIVE DUTY FAMILY                                          500        1
  MED MEDICARE                                                    500        0
  OTH OTHER                                                       500        0
  RET RETIREE                                                     500        0
  RFM RETIREE FAMILY MEM                                          500        0
```

Figure 2-122. Provider Group Report - Primary Care Managers

2.2.4.1.3 Provider List by Specialty

Menu Path: PAS System Menu → M → PMCP → ONET → GMRM → 3

- **Security Keys**

CPZ CCP

CPZ NET
CPZ FILE

- **Contents**

The Provider List by Specialty option allows you to print reports listing providers by provider type and specialty. The report totals TRICARE providers by provider type and by specialty
You can select to print reports for network providers, and for one, multiple, or all specialties, or to print reports for one, multiple or all TRICARE provider types and by one, multiple, or all specialties.

- **Use/Frequency**

As needed. This report should be run to determine if all specialties are appropriately covered by the network. The report allows you to evaluate the types of agreements in the network and the distribution across specialties, as well as expiration dates and discounts.

- **Report Sample**

Refer to Figure 2-123. Provider List by Specialty, page 2-253.

```
WALTER REED AMC                                                                    21 Jun 2001@1531    Page 1
                                    Personal Data - Privacy Act of 1974 (PL 93-579)
                                              Provider List By Specialty
Provider Type: NETWORK PROVIDER GROUP
================================================================================================================
==
Specialty
    Provider Group                          Place(s) of Care     POC Phone                POC ZIP Code
        Agreement Type                                               Effective Date   Stop Date          Disc %
Except
================================================================================================================
==
FAMILY PRACTICE/PRIMARY CARE
----------------------------
    ACUTE CR BC                             ACUTE CR BC          202 361-4241             20301
        MTF - MTF STAFF                                             01 Jan 01        01 Jan 05      MTF
    ACUTE CR MTF                            ACUTE CR MTF         202 271-5851             20307
        MTF - MTF STAFF                                             01 Jan 01        01 Jan 05      MTF
    ADULT PR CR BC                          ADULT PR CR BC       202 361-4245             20301
        MTF - MTF STAFF                                             01 Jan 01        01 Jan 05      MTF
    ADULT PR CR MTF                         ADULT PR CR MTF      202 271-5850             20307
        MTF - MTF STAFF                                             01 Jan 01        01 Jan 05      MTF
    AMB CARE MTF                            AMB CARE MTF         202 271 -5853             20307
        MTF - MTF STAFF                                             01 Jan 01        01 Jan 05      MTF
    AMB CR BC                               AMB CR BC            202 361-4244             20301
        MTF - MTF STAFF                                             01 Jan 01        01 Jan 05      MTF
    ENT CLINIC                              ENT CLINIC           202 272-5855             20307
        MTF - MTF STAFF                                             01 Jan 01        01 Jan 05      MTF
    FAM PRAC ASSOC                          FAM PRAC ASSOC       301 544-1232             20817
        NET - CIVILIAN NETWORK PROVIDER                             01 Jan 01        01 Jan 05      CA-15%
    FAM PRAC BC                             FAM PRAC BC          202 361-4240             20301
        MTF - MTF STAFF                                             01 Jan 01        01 Jan 05      MTF
    FAM PRAC MTF                            FAM PRAC MTF         202 271-5850             20307
        MTF - MTF STAFF                                             01 Jan 01        01 Jan 05      MTF
    GEN MED BC                              GEN MED BC           202 361-4242             20301
        MTF - MTF STAFF                                             01 Jan 01        01 Jan 05      MTF
    INT MED BC                              INT MED BC           202 361-4243             20301
        MTF - MTF STAFF                                             01 Jan 01        01 Jan 05      MTF
    INT MED MTF                             INT MED MTF          202 271-5852             20307
```

Figure 2-123. Provider List by Specialty

2.2.4.1.4 PCM Enrollment Mix Discrepancy Statistical Summary

Menu Path: PAS System Menu ® M ® PMCP ® ONET ® GMRM ® 4

Alternate Menu Paths:

PAS System Menu ® M ® OMCP ® PRPT ® 7

PAS System Menu ® M ® EMCP ® OENR ® PRPM ® 7

- **Security Keys**

CPZ CCP
CPZ NET
CPZ FILE

- **Contents**

The PCM Enrollment Mix Discrepancy Statistical Summary option allows you to generate and print reports identifying PCMs whose patient loads exceed their PCM capacity for one or more beneficiary categories or who have beneficiaries assigned to them whose ages are outside of the PCM assigned age range preferences. The system allows you to sort by PCM or by group. Within each PCM or group, the system sorts by agreement. The report identifies PCM beneficiary categories that have discrepancies with an asterisk and displays the numeric value of the discrepancies. The system allows you to sort by group or by PCM and to select One, Multiple, or All of the selected category. The report lists the groups alphabetically and, within each group, lists the providers alphabetically. It includes a statistical summary of the group's capacity and age range preferences and associated patient load, as well as the statistics for each of the providers within the selected group. The report sorted by PCM lists alphabetically all PCMs who have discrepancies and includes a statistical summary of their capacity, age range preferences and associated patient load. The report does not include groups or individual providers who have no discrepancies. The report indicates the number of enrollees who are over assigned or whose age exceeds the authorized age range for the PCM.

- **Use/Frequency**

Monthly/As needed

- **Report Sample**

Refer to Figure 2-124. PCM Enrollment Mix Discrepancy Statistical Summary, page 2-256.

```
TRIPLER ARMY MEDICAL CENTER                    24 Oct 1995@1440    Page 1

               Personal Data - Privacy Act of 1974 (PL 93-579)
                    PCM ENROLLMENT MIX DISCREPANCY STATISTICAL SUMMARY
                                 by PROVIDER group

Provider GROUP: WOLLIN GROUP PCM CAPACITY
-------------------------------------------------------------------------------
-
 Agreement Type: NON - NON-NETWORK/EXCEPTION
Agreement Dates: 29 Aug 1995 - 28 Aug 1996
      Group PCM: YES

Maximum Patient Capacity:    30         Age Range to Apply Overall: 1 - 2
          Total Assigned:    17
===============================================================================
=
                                                      Total     Pat out of
PCM Beneficiary Category    Age  Range   Capacity     Assigned  Age Range
-------------------------------------------------------------------------------
-
ACTIVE DUTY                 1    -   2       30           11          8
ACTIVE DUTY FAMILY MEMBER   1    -   2        0
RETIREE                     1    -   2        0
RETIREE FAMILY MEMBER       1    -   2        0
MEDICARE
OTHER                       1    -   2        0           6 *         2
===============================================================================
=
        THE FOLLOWING INDIVIDUAL PROVIDERS WITHIN THIS GROUP HAVE EITHER
                CAPACITY OR AGE RANGE DISCREPANCIES AS INDICATED.


                                                                      Page 2
       Provider: WOLLIN,MAGDALENA
 Agreement Type: NON - NON-NETWORK/EXCEPTION
Agreement Dates: 29 Aug 1995 - 28 Aug 1996

Maximum Patient Capacity:    18         Age Range to Apply Overall: 16 -
          Total Assigned:    17
===============================================================================
=
                                                      Total     Pat out of
PCM Beneficiary Category    Age  Range   Capacity     Assigned  Age Range
-------------------------------------------------------------------------------
-
ACTIVE DUTY                 16   -           0                      8
ACTIVE DUTY FAMILY MEMBER   16   -                       11
RETIREE                     16   -
RETIREE FAMILY MEMBER       16   -
MEDICARE
OTHER                       16   -           0           6 *         2
===============================================================================
=
(*) indicates # of beneficiaries Assigned is greater than Capacity
```

Figure 2-124. PCM Enrollment Mix Discrepancy Statistical Summary

2.2.4.1.5 PCM Enrollment Mix Discrepancy Report

Menu Path: PAS System Menu ® M ® PMCP ® ONET ® GMRM ® 5

- **Security Keys**

CPZ CCP
CPZ NET
CPZ FILE

- **Contents**

This report includes the statistics from the PCM Enrollment Mix Discrepancy Summary Report and the names of the individual beneficiaries who are currently assigned to PCMs in categories where the number of assigned beneficiaries exceed the PCMs capacity for that category, or whose age is outside the PCM age-range preference.
You may choose to sort the report by PCM, by TRICARE Provider Group, or by beneficiary.

- **Use/Frequency**

As needed

- **Report Sample**

Refer to Figure 2-125. PCM Enrollment Mix Discrepancy Report, page 2-258.

```
 PORTSMOUTH NH                                                                                    15 Jun 1995@1530      Page 1
                                        Personal Data - Privacy Act of 1974 (PL 93-579)
                                         PCM ENROLLMENT MIX DISCREPANCY REPORT by PCM
PCM: BENJAMIN,ARTHUR
-------------------------------------------------------------------------------------------------------------------------------
 Provider Group: DE ANZA PEDIATRIC GROUP                                          Maximum Patient Capacity:      100
 Agreement Type: CON - CONTRACT                                                             Total Assigned:       82
Agreement Dates: 01 Jan 1995 - 31 Dec 1995                                     Age Range to Apply Overall:        -
      Group PCM: YES
===============================================================================================================================
                                                                                                      Total          Pat out of
PCM Beneficiary Category                                                  Age Range      Capacity     Assigned        Age Range
-------------------------------------------------------------------------------------------------------------------------------
ACTIVE DUTY                                                                                 0
ACTIVE DUTY FAMILY MEMBER                                                 0   -   18       75           82*            Y
RETIREE                                                                                     0
RETIREE FAMILY MEMBER                                                     0   -   16       25
MEDICARE                                                                                    0
OTHER                                                                                       0
                                                                  (*)  indicates # if beneficiaries Assigned is greater than Capacity
PCM Beneficiary Category: ACTIVE DUTY FAMILY MEMBER
===============================================================================================================================
DMIS                                          Pat     Spon    Case          Home    Duty                      Date
 ID     Spon SNN  FMP  Beneficiary Name       Cat     Rank    Mgmt    Age   Zip     Zip     Home Phone     Assigned       Reason
-------------------------------------------------------------------------------------------------------------------------------
1384    213-76-4345/02 JACKSON,ADRIANNE       K84     AO3       N      13    92029   92121   619-567-9876   15 Dec 1994     EX
1384    213-76-4345/03 JACKSON,THOMAS         K84     A03       N       8    92029   92121   619-567-9876   16 Feb 1995     EX
1384    213-76-4345/04 JACKSON,WINDSOR        K84     A03       N       4    92029   92121   619-567-9876   16 Feb 1995     EX
1384    213-76-4345/05 JACKSON,ZELDA          K84     A03       N     03M    92029   92121   619-567-9876   22 May 1995      EX
3002    111-75-9620/02 ABLE,JOHN              K84     NE5       N      17    92134   92122   619-345-2534    8 Apr 1995     EX
3002    138-83-6549/02 SMITH,ALEXIA           K84     AO5       Y      19    92211   92121   619-999-3353    3 Jan 1995     EX/AX
6214    111-57-8533/04 MIDLER,NANCY           K84     FE5       N       5    92117   92121   619-863-5545   30 May 1995     EX
6214    140-57-8533/02 RODRIQUEZ,HECTOR       K84     FE5       N      18    92117   92121   619-863-5545    4 Oct 1994     EX
6214    140-57-8533/03 RODRIQUEZ,TERRANCE     K84     FE5       N      15    92117   92121   619-863-5545    4 Oct 1994     EX
6214    164-75-9620/02 GEARY,CONNIE           K84     AE2       N       3    92323   92121   619-567-4343   17 Mar 1995     EX
... [etc. There would be 82 names altogether, if the list were completed.]
```

Figure 2-125. PCM Enrollment Mix Discrepancy Report

```
                                                Active Duty Family Members assigned to this PCM    = 82
                                      Active Duty Family Members assigned to this PCM in excess of capacity (EX)  =  7
                            Active Duty Family Members assigned to this PCM who are out-of-age-range (AX)      = 14
                                                          Total beneficiaries assigned to this PCM    = 82
                                  Total beneficiaries assigned to this PCM in excess of capacity (EX)   =  3
                                Total beneficiaries assigned to this PCM who are out-of-age range (AX)  = 14
```

Figure 2-125. PCM Enrollment Mix Discrepancy Report (continued)

2.2.4.2 Agreement Reports Menu (AMRM)

Menu Path: PAS System Menu ® M ® PMCP ® ONET ® AMRM

Refer to Figure 2-126. Agreements Reports Menu (AMRM), page 2-260, and Sections 2.2.4.2.1-6.

```
   1      Provider Alphabetic Agreement Roster
   2      Specialty Provider Agreement Roster
   3      Specialty Provider Agreement Summary
   4      Discount Provider Agreement Roster
   5      Expiration Date Provider Agreement Roster
   6      ZIP Code Agreement Roster

Select Agreement Reports Menu Option:
```

Figure 2-126. Agreements Reports Menu (AMRM)

2.2.4.2.1 Provider Alphabetic Agreement Roster

Menu Path: PAS System Menu ® M ® PMCP ® ONET ® AMRM ® 1

- **Security Keys**

CPZ CCP
CPZ NET
CPZ FILE

- **Contents**

The Provider Alphabetic Agreement Roster option allows you to print reports alphabetically listing current provider agreement data. The listed agreement data includes provider, specialty, provider group, effective date, stop date, discount, and exceptions indicator.

You can select one, multiple, or all provider types for the roster. The agreements are sorted by provider type, provider name, and provider group. Specialties are listed for each provider. Agreements are totaled by provider type.

If you select network, the report is sorted by three provider types that imply network membership: Network Individual Provider, Network Institution/Service, and Network Provider Group. Report data is the same as if selected by one, multiple, or all provider types.

- **Use/Frequency**

As needed

- **Report Sample**

Refer to Figure 2-127. Provider Alphabetic Roster, page 2-262.

```
WALTER REED AMC                                                                    21 Jun 2001@1802    Page 1
                                    Personal Data - Privacy Act of 1974 (PL 93-579)
                                          PROVIDER ALPHABETIC AGREEMENT ROSTER

Provider Type: NETWORK PROVIDER GROUP
=============================================================================================================================
Group Name                                Specialty
         Agreement Type                                                 Effective Date   Stop Date         Disc %     Except
=============================================================================================================================
ACUTE CR BC                               FAMILY PRACTICE PHYSICIAN
                                          FAMILY PRACTICE/PRIMARY CARE
                                          PRIMARY CARE NURSE PRACTITIONER QUALIFIED
         CON - CONTRACT                                                 01 Jan 2001      01 Jan 2005       CA-60%
         MTF - MTF STAFF                                                01 Jan 2001      01 Jan 2005       MTF
         PIC - PARTNER INTERNAL                                         01 Jan 2001      01 Jan 2005       CA-40%

ACUTE CR MTF                              FAMILY PRACTICE PHYSICIAN
                                          FAMILY PRACTICE/PRIMARY CARE
                                          PRIMARY CARE NURSE PRACTITIONER QUALIFIED
         CON - CONTRACT                                                 01 Jan 2001      01 Jan 2005       CA-60%
         MTF - MTF STAFF                                                01 Jan 2001      01 Jan 2005       MTF
         PIC - PARTNER INTERNAL                                         01 Jan 2001      01 Jan 2005       CA-40%

ADULT PR CR BC                            FAMILY PRACTICE PHYSICIAN
                                          FAMILY PRACTICE/PRIMARY CARE
                                          PRIMARY CARE NURSE PRACTITIONER QUALIFIED
         CON - CONTRACT                                                 01 Jan 2001      01 Jan 2005       CA-60%
         MTF - MTF STAFF                                                01 Jan 2001      01 Jan 2005       MTF
         PIC - PARTNER INTERNAL                                         01 Jan 2001      01 Jan 2005       CA-40%

ADULT PR CR MTF                           FAMILY PRACTICE PHYSICIAN
                                          FAMILY PRACTICE/PRIMARY CARE
                                          PRIMARY CARE NURSE PRACTITIONER QUALIFIED
         CON - CONTRACT                                                 01 Jan 2001      01 Jan 2005       CA-60%
         MTF - MTF STAFF                                                01 Jan 2001      01 Jan 2005       MTF
         PIC - PARTNER INTERNAL                                         01 Jan 2001      01 Jan 2005       CA-40%

ALLERGY                                   ALLERGIST
         MTF - MTF STAFF                                                01 Jan 2001      01 Jan 2005       MTF

AMB CARE MTF                              FAMILY PRACTICE PHYSICIAN
                                          FAMILY PRACTICE/PRIMARY CARE
                                          PRIMARY CARE NURSE PRACTITIONER QUALIFIED
         CON - CONTRACT                                                 01 Jan 2001      01 Jan 2005       CA-60%
         MTF - MTF STAFF                                                01 Jan 2001      01 Jan 2005       MTF
         PIC - PARTNER INTERNAL                                         01 Jan 2001      01 Jan 2005       CA-40%
```

Figure 2-127. Provider Alphabetic Roster

2.2.4.2.2 Provider Agreement Roster by Specialty

Menu Path: PAS System Menu ® M ® PMCP ® ONET ® AMRM ® 2

- **Security Keys**

CPZ CCP
CPZ NET
CPZ FILE

- **Contents**

The Specialty Provider Agreement Roster option allows you to print agreement rosters for all active network providers for one, multiple, or all provider types by one, multiple, or all specialties. Totals are provided for specialty for provider type.
For provider types that imply individuals, the roster lists the provider's group agreements and the associated effective dates, stop dates, discounts, and exception indicators. For providers types that imply groups, for each specialty, the roster lists the agreement, group, effective stop date, discount rate and exceptions.

- **Use/Frequency**

As needed

- **Report Sample**

Refer to Figure 2-128. Provider Agreement Roster by Specialty, page 2-264.

```
WALTER REED AMC                      Personal Data - Privacy Act of 1974 (PL 93-579)      21 Jun 2001@1846    Page 1
                                              PROVIDER AGREEMENT ROSTER BY SPECIALTY
Provider Type: NETWORK INDIVIDUAL PROVIDER
=============================================================================================================================
Specialty    Agreement  Provider   Group                        Effective Date     Stop Date          Disc %    Except
=============================================================================================================================
CARDIOLOGIST
             MTF - MTF STAFF
                        CALDWELL,LORRAINE C
                                   CARDIOLOGY                   01 Jan 2001        31 Dec 2004           MTF
             NET - CIVILIAN NETWORK PROVIDER
                        PARNELL,DOUGLASS C
                                   GEORGETOWN MED               01 Jan 2001        01 Jan 2005       CA-12%
                        PEPYS,ANN C
                                   GEORGETOWN MED               01 Jan 2001        01 Jan 2005       CA-12%
                        PERRON,CAROL C
                                   GEORGETOWN MED               01 Jan 2001        01 Jan 2005       CA-12%
                        PHIDIAS,ELISA C
                                   GEORGETOWN MED               01 Jan 2001        01 Jan 2005       CA-12%
                        PLEASANCE,FRANK C
                                   GEORGETOWN MED               01 Jan 2001        01 Jan 2005       CA-12%
                        POMPEY,JOSEPH C
                                   GEORGETOWN MED               01 Jan 2001        01 Jan 2005       CA-12%
                        POST,HENRY C
                                   GEORGETOWN MED               01 Jan 2001        01 Jan 2005       CA-12%
                        PROUDFOOT,GEORGETTE C
                                   GEORGETOWN MED               01 Jan 2001        01 Jan 2005       CA-12%
                        PSKOV,IVANA C
                                   GEORGETOWN MED               01 Jan 2001        01 Jan 2005       CA-12%
                        PUSHKIN,ZELDA C
                                   GEORGETOWN MED               01 Jan 2001        01 Jan 2005       CA-12%
                        PYRAMUS,BASIL C
                                   GEORGETOWN MED               01 Jan 2001        01 Jan 2005       CA-12%
                              CARDIOLOGIST Provider Totals:   12         Total providers all specialties:   12
-----------------------------------------------------------------------------------------------------------------------------
* To see Group Providers, select a Group-level Provider Type.
```

Figure 2-128. Provider Agreement Roster by Specialty

2.2.4.2.3 Specialty Provider Agreement Summary

Menu Path: PAS System Menu ® M ® PMCP ® ONET ® AMRM ® 3

- **Security Keys**

CPZ CCP
CPZ NET
CPZ FILE

- **Contents**

The Specialty Provider Agreement Summary option allows you to print a summary report giving the number of agreements by provider type, provider specialty, and agreement type. Totals are given for agreements pertaining to a provider type. Grand totals are provided for the entire facility.

- **Use/Frequency**

As needed. This report should be run when there is a need to determine the volume of agreements in effect on the report run date and the specialties and agreement types supported.

- **Report Sample**

Refer to Figure 2-129. Provider Agreement Summary by Specialty, page 2-266.

```
WALTER REED AMC                                    21 Jun 2001@1903    Page 1
                Personal Data - Privacy Act of 1974 (PL 93-579)
                     PROVIDER AGREEMENT SUMMARY BY SPECIALTY

Provider Type: NETWORK INDIVIDUAL PROVIDER
=========================================================================
Specialty
   Agreement                                              Number Agreements
=========================================================================
CARDIOLOGIST
-----------
   MTF - MTF STAFF                                                     1
   NET - CIVILIAN NETWORK PROVIDER                                    11

         TOTAL AGREEMENTS FOR SPECIALTY CARDIOLOGIST:                 12

 TOTAL AGREEMENTS PROVIDER TYPE NETWORK INDIVIDUAL PROVIDER:          12
```

Figure 2-129. Provider Agreement Summary by Specialty

2.2.4.2.4 Discount Provider Agreement Roster

Menu Path: PAS System Menu ® M ® PMCP ® ONET ® AMRM ® 4

- **Security Keys**

CPZ CCP
CPZ NET
CPZ FILE

- **Contents**

The Discount Provider Agreement Roster option allows you to print reports showing all active provider agreements by discount. Totals are provided showing the total number of providers for each discount rate. The report is sorted by agreement type, provider type, provider specialty, and discount rate.

- **Use/Frequency**

As needed

- **Report Sample**

Refer to Figure 2-130. Discount Provider Agreement Roster, page 2-267.

```
WALTER REED AMC                                    21 Jun 2001@1907    Page
1
                Personal Data - Privacy Act of 1974 (PL 93-579)

                     PROVIDER AGREEMENT ROSTER by DISCOUNT
```

```
                          Agreement Type: CONTRACT

================================================================================
Provider Type: NETWORK INDIVIDUAL PROVIDER
================================================================================
Specialty: FAMILY PRACTICE PHYSICIAN
  Discount: CA-60%
                    PEBBLE,HENRY O
                         INT MED BC
                    PEPPER,CORBEN O
                         AMB CARE MTF
                    PEREGRINE,DEAN O
                         ADULT PR CR MTF
                    PEWTER,FORMAN O
                         ACUTE CR BC
                    PHILL,JEROME O
                         ADULT PR CR BC
                    PINSKY,ZACH O
                         FAM PRAC MTF
                    POKORNY,BRANDON O
                         INT MED MTF
                    POLLMAN,EARL O
                         FAM PRAC BC
                    PONY,ALAN O
                         ACUTE CR MTF
                    POTOMAC,IAN O
                         AMB CR BC
                    PRISCO,GRANT O
                         GEN MED BC

                                                TOTAL PROVIDERS AT CA-60%: 11
```

Figure 2-130. Discount Provider Agreement Roster

```
WALTER REED AMC                                          21 Jun 2001@1907    Page
2
                Personal Data - Privacy Act of 1974 (PL 93-579)

                     PROVIDER AGREEMENT ROSTER by DISCOUNT
                     Agreement Type: CONTRACT  (continued)

================================================================================
Provider Type: NETWORK PROVIDER GROUP
================================================================================
Specialty: FAMILY PRACTICE PHYSICIAN
  Discount: CA-60%
                   ACUTE CR BC
                   ACUTE CR MTF
                   ADULT PR CR BC
                   ADULT PR CR MTF
                   AMB CARE MTF
                   AMB CR BC
                   FAM PRAC BC
                   FAM PRAC MTF
                   GEN MED BC
                   INT MED BC
                   INT MED MTF

                                                  TOTAL GROUPS AT CA-60%: 11
```

Figure 2-130. Discount Provider Agreement Roster (continued)

2.2.4.2.5 Expiration Date Provider Agreement Roster

Menu Path: PAS System Menu ® M ® PMCP ® ONET ® AMRM ® 5

- **Security Keys**

CPZ CCP
CPZ NET
CPZ FILE

- **Contents**

The Expiration Date Provider Agreement Roster option allows you to print reports of TRICARE provider agreements which expire within a specified date range for one, multiple, or all agreement types. It is sorted alphabetically by provider, and within provider, by provider group. The report displays provider agreement and specialty data. Subtotals are shown at the end of the report for the agreement types with an overall total for all agreements shown on the report.

- **Use/Frequency**

Monthly or as needed

- **Report Sample**

Refer to Figure 2-131. Expiration Date Provider Agreement Roster, page 2-270.

```
TIDEWATER                                                                    01 Oct 1993@1242    Page 1
                                        Personal Data - Privacy Act of 1974 (PL 93-579)
                                        Provider Agreement Roster By Expriation Date
                                           Period from 16 Sep 1993 to 01 Dec 1993
================================================================================================================================
Provider                                                  Specialty
     Provider Group
          Payment Address                                                                  Zip Code        Phone Number
          Agreement Type                                                 Effective Dates            Disc %        Except
================================================================================================================================
ABBOTT,JAMES                                              GENERAL SURGEON
                                                          INTERNAL MEDICINE
                                                          INTERNAL MEDICINE CONSULTANT
    SALISBURY TRAINING GROUP
         6275 RANCHO MISSION ROAD                         PORTSMOUTH, VA                    23667          (804) 780-0520
         SUP - SUPPLEMENTAL CARE/DIAGNOSTIC SERVICES                    18Oct92-17Oct93            CA-10%         E

     RIVERSIDE MEDICAL
        P O BOX 5436                                      HAMPTON, VA                       23669          (804) 890-5432
        833 OLD HAMPTON PARKWAY
        NET - CIVILIAN NETWORK PROVIDER                                 01Oct92-01Oct93            CA-12%

ACEVES,ALICIA                                             GENERAL SURGEON
     RIVERSIDE MEDICAL
        P O BOX 5436                                      HAMPTON, VA                       23669          (804) 890-5432
        833 OLD HAMPTON PARKWAY
        NET - CIVILIAN NETWORK PROVIDER                                 05Sep92-05Sep93            CA-17%
        PEX - PARTNER EXTERNAL                                          01Oct92-01Oct93            CA-12%

BALLANTINE,ELAINE G                                       OPHTHALMOLOGIST
     RIVERSIDE MEDICAL
        P O BOX 5436                                      HAMPTON, VA                       23669          (804) 890-5432
        833 OLD HAMPTON PARKWAY
        NET - CIVILIAN NETWORK PROVIDER                                 01Oct92-01Oct93            CA-12%
```

Figure 2-131. Expiration Date Provider Agreement Roster

TIDEWATER 01 Oct 1993@1242 Page 7

Personal Data - Privacy Act of 1974 (PL 93-579)
Provider Agreement Roster By Expriation Date
Period from 16 Sep 1993 to 01 Dec 1993

Agreement Type	Total
CON - CONTRACT	1
MTF - MTF STAFF	2
NET - CIVILIAN NETWORK PROVIDER	21
NON - NON-NETWORK/EXCEPTION	2
PEX - PARTNER EXTERNAL	1
PIC - PARTNER INTERNAL	1
SUP - SUPPLEMENTAL CARE/DIAGNOSTIC SERVICES	1
Total Agreements	29

Figure 2-131. Expiration Date Provider Agreement Roster (continued)

2.2.4.2.6 ZIP Code Agreement Roster

Menu Path: PAS System Menu ® M ® PMCP ® ONET ® AMRM ® 6

- **Security Keys**

CPZ CCP
CPZ NET
CPZ FILE

- **Contents**

The ZIP Code Agreement Roster option allows you to print rosters listing and totaling providers by ZIP Code and specialty. You can generate a roster for a single ZIP Code or a ZIP Code combination, for one, multiple or all specialties. You may do it for all providers or for PCMs.

- **Use/Frequency**

Monthly or as needed

- **Report Sample**

Refer to Figure 2-132. ZIP Code Agreement Roster, page 2-273.

```
      WALTER REED AMC                                                                    21 Jun 2001@1922    Page 1
                                        Personal Data - Privacy Act of 1974 (PL 93-579)
                                             Provider Agreement Roster By ZIP Code
                                                        ZIP Code: 20817
                                                          **PCM only**
================================================================================================================
==
      Specialty
          Provider
              Provider Group
                  Agreement Type                                  Effective Dates            Disc %
Except

================================================================================================================
==
      FAMILY PRACTICE PHYSICIAN
      -------------------------
          HARVARD,STANLEY C
              FAM PRAC ASSOC
                  NET - CIVILIAN NETWORK PROVIDER                 01Jan01-01Jan05            CA-10%        E
          PAWLOW,GEORGE C
              FAM PRAC ASSOC
                  NET - CIVILIAN NETWORK PROVIDER                 01Jan01-01Jan05            CA-15%
          PEDRONE,HARRY C
              FAM PRAC ASSOC
                  NET - CIVILIAN NETWORK PROVIDER                 01Jan01-01Jan05            CA-15%
          PETITO,FRED C
              FAM PRAC ASSOC
                  NET - CIVILIAN NETWORK PROVIDER                 01Jan01-01Jan05            CA-15%
          PHEE,LONI C
              FAM PRAC ASSOC
                  NET - CIVILIAN NETWORK PROVIDER                 01Jan01-01Jan05            CA-15%
          PIES,BERNICE C
              FAM PRAC ASSOC
                  NET - CIVILIAN NETWORK PROVIDER                 01Jan01-01Jan05            CA-15%
          PLUTO,ARMAND C
              FAM PRAC ASSOC
                  NET - CIVILIAN NETWORK PROVIDER                 01Jan01-01Jan05
```

Figure 2-132. ZIP Code Agreement Roster

```
      PUGLIA,MARGARET C
              FAM PRAC ASSOC
                  NET - CIVILIAN NETWORK PROVIDER                 01Jan01-01Jan05            CA-15%
                                                                 Total providers for FAMILY PRACTICE PHYSICIAN:    8
      FAMILY PRACTICE/PRIMARY CARE
      ----------------------------
          PADFIELD,GRACE C
              FAM PRAC ASSOC
                  NET - CIVILIAN NETWORK PROVIDER                 01Jan01-01Jan05            CA-15%
          PROVOST,PHILLIP C
              FAM PRAC ASSOC
                  NET - CIVILIAN NETWORK PROVIDER                01Jan01-01Jan05            CA-15%
                                                                Total providers for FAMILY PRACTICE/PRIMARY CARE:    2

 WALTER REED AMC                                                                          21 Jun 2001@1922    Page 2
                                       Personal Data - Privacy Act of 1974 (PL 93-579)
                                            Provider Agreement Roster By ZIP Code
                                                       ZIP Code: 20817
                                                         **PCM only**
==========================================================================================================================
      Specialty
          Provider
              Provider Group
                  Agreement Type                                        Effective Dates            Disc %        Except
      ==========================================================================================================================
      PRIMARY CARE NURSE PRACTITIONER QUALIFIED
      -----------------------------------------
          PHILPS,REBECCA C
              FAM PRAC ASSOC
                  NET - CIVILIAN NETWORK PROVIDER                            01Jan01-01Jan05            CA-15%

          PYPER,ALBERTO C
              FAM PRAC ASSOC
                  NET - CIVILIAN NETWORK PROVIDER                            01Jan01-01Jan05            CA-15%

                                                       Total providers for PRIMARY CARE NURSE PRACTITIONER QUALIFIED:    2
                                                                            Total providers for ZIP Code 20817:   12
```

Figure 2-132. ZIP Code Agreement Roster (continued)

2.2.4.3 Miscellaneous Network Reports Menu (MMRM)

Menu Path: PAS System Menu ® M ® PMCP ® ONET ® MMRM

Refer to Figure 2-133. Miscellaneous Network Reports Menu (MMRM), page 2-275, and Sections 2.2.4.3.1-3.

```
   1      Provider Batch Address Labels - Build Utility
   2      Provider Batch Address Labels - Print Utility
   3      Discrepancy Avoidance Report

Select Miscellaneous Network Reports Menu Option:
```

Figure 2-133. Miscellaneous Network Reports Menu (MMRM)

2.2.4.3.1 Provider Batch Address Labels – Build Utility

Menu Path: PAS System Menu ® M ® PMCP ® ONET ® MMRM ® 1

- **Security Keys**

CPZ CCP
CPZ NET
CPZ FILE
CPZ LABEL

- **Application Description**

The Provider Batch Address Labels - Build Utility option allows you to select providers by provider name, agreement type, specialty, or expiration date to generate provider payment address labels. You can specify one, multiple, or all providers, one, multiple, or all agreement types, and one, multiple, or all specialties.

Note: When selecting providers by agreement type, you must also specify an expiration date. The system only selects providers who participate in a specified agreement that expires on that specified date.
When specifying selection by an expiration date without selecting agreements, the system selects providers who participate in any agreement that expires on the specified date.
When you specify a provider for the search, the system searches the Provider file by the specified provider name for label generation.

Based on the search criteria entered, the system searches the MCP Provider file for all providers that meet the specified search criteria.
The providers that meet the search criteria during the above search and have complete payment

address information are placed in a global file which may be used to generate and print labels using the Provider Batch Address Labels - Print Utility option.
The providers that meet the search criteria during the above search but have incomplete (missing) payment address information are placed in a global file which may be generated and printed using the Incomplete Provider Address Report option.

- **Use/Frequency**

As needed

- **Report Sample**

Not applicable.

2.2.4.3.2 Provider Batch Address Labels – Print Utility

Menu Path: PAS System Menu ® M ® PMCP ® ONET ® MMRM ® 2

- **Security Keys**

CPZ CCP
CPZ NET
CPZ FILE
CPZ LABEL

- **Application Description**

The Provider Batch Address Labels - Print Utility option allows you to print provider address labels which were compiled using the Provider Batch Address Labels - Build Utility option.

The system allows you to display a picklist of all global label batches compiled at various times for a specific user or for all users. After you select a batch from the picklists, you can print the labels, delete the batch, or view the search criteria that were used to compile the labels.

You can print a batch of labels in its entirety or print a subset of the batch. If you elect to print a subset, the system prompts you to indicate the number of labels to print and then prints that number of labels in alphabetical order. After the system prints a label, that label is deleted and cannot be reprinted. If all labels in the batch are printed, the batch is no longer accessible through this option. Batches of labels remain on the system until all labels have been printed or until a user deletes the batches through this option.

- **Use/Frequency**

As needed.

- **Report Sample**

Refer to Figure 2-134. Provider Address Label, page 2-278.

```
User: SLATER,PAMELA
Provider: ESCALERA,FRANK M



TO:
CPT  FRANK M ESCALERA
PO BOX 421683
WASHINGTON DC
20301
```

Figure 2-134. Provider Address Label

2.2.4.3.3 Discrepancy Avoidance Report

Menu Path: PAS System Menu ® M ® PMCP ® ONET ® MMRM ® 3

- **Security Keys**

CPZ CCP
CPZ NET
CPZ FILE

- **Contents**

The Discrepancy Avoidance Report option allows you to generate a report that informs you of the groups, providers, and patients in a given place of care or providers that must be changed before the place of care or provider may be inactivated. Whenever providers or places of care are inactivated, the system checks for any discrepancies linked to the inactivation. If discrepancies are found, the system prompts you to generate a Discrepancy Avoidance Report. This report lists any pending appointments/Wait List requests, PCM assignments, or referral numbers linked to the inactivated provider or place of care.

As soon as an inactivation is filed, a mail bulletin is automatically sent to the CPZMGR mail group. This bulletin notifies mail group members the date on which inactivated providers' profiles, templates, and schedules will be deleted. This bulletin also reminds CPZMGR mail group members to generate the Discrepancy Avoidance Report.

In CHCS Version 4.5, no provider or place of care could be inactivated until all discrepancies listed in the Discrepancy Avoidance Report were resolved. In CHCS Version 4.6, as soon as provider/place of care inactivations are filed, they become effective immediately on the inactivation date entered on the Provider Inactivation from A Group screen, the Provider Inactivation from All Groups screen, or the Inactivation/Reactivation of Place of Care screen. Refer to Figure 2-101. Inactivation/Reactivation of Place of Care Screen, page 2-216. The inactivation date can be in the past, today's date, or in the future.

Members of the CPZMGR mail group are responsible for resolving discrepancies listed on the Discrepancy Avoidance Report by rescheduling pending appointments, modifying Wait List requests, and reassigning patients to a different PCM.

If this report is generated for a given **place of care**, you can choose one of three selection criteria:

- All providers in all groups
- A single group
- A single provider in a single group.

The report consists of four sections. Each section is sorted first by groups to which the place of care belongs, and then by providers within the group and place of care. The sections contain the following data:

- Patients assigned to providers as PCMs
- Patients having appointments with and referrals to providers
- Patients having Wait List requests for providers
- Providers in each group.

If this report is generated for a given **provider**, you can choose one of two selection criteria:

- All groups
- Selected groups.

The report consists of four sections. Each section is sorted first by groups to which the provider belongs, and then by places of care for the provider within the group. The sections contain the following data:

- Patients assigned to the provider as a PCM

- Patients having appointments with and referrals to the provider
- Patients having Wait List requests for the provider
- Places of care in each group.

You can also generate this report from those options that perform inactivations and reactivations:

- The Group Profile/Agreements Enter/Edit option
  - A place of care can be inactivated from a group
  - A place of care can be inactivated from a provider
  - A provider can be inactivated from a group
- The Individual Provider Profile/Agreements Enter/Edit option
  - A place of care can be inactivated from a provider
  - A provider can be inactivated from a group
- The Provider Enter/Edit option
  - A provider can be inactivated from all of MCP.

- **Use/Frequency**

As needed

- **Report Sample**

Refer to Figure 2-135. Discrepancy Avoidance Report, page 2-281.

```
TRAINING MEDICAL TREATMENT FACILITY                    21 Jun 2001@1946    Page
1
                          DISCREPANCY AVOIDANCE REPORT
                Personal Data - Privacy Act of 1974 (PL 93-579)
         *** Patients assigned to Provider as Primary Care Manager ***

Provider: ENRIQUEZ,FRANK M
================================================================================
Provider Group
   Place of Care
      Patient                              FMP/SSN
================================================================================
 ACUTE CR MTF
   ACUTE CR MTF
      PICARD,AUGUST E                     20/379-43-6100

================================================================================
Use the Batch PCM Reassignment Option (BMCP) to transfer assigned patients.

TRAINING MEDICAL TREATMENT FACILITY                    21 Jun 2001@1946    Page
2
                          DISCREPANCY AVOIDANCE REPORT
                Personal Data - Privacy Act of 1974 (PL 93-579)
                      *** Provider Hospital Locations ***

Provider: ENRIQUEZ,FRANK M
================================================================================
Provider Group
   Place of Care
================================================================================
 ACUTE CR MTF
   ACUTE CR MTF
```

Figure 2-135. Discrepancy Avoidance Report

2.3 TaskMan Options

Menu Path: Systems Manager Menu (EVE) ® TM ® STT ® Enter name of TaskMan option to schedule

- **Security Keys**

ZTMMGR

- **Required Fields**

Option to Task
Queue to Run at Date/Time
Rescheduling Frequency

- **Application Description**

Options may be setup by TaskMan to automatically run an operation and reschedule it to run at a new time. In MCP, several TaskMan options run processes that generate reports, bulletins, and update enrollment transactions. Scheduling these options is the systems specialist's responsibility. File and table personnel, should be aware of them also.

- **Business Rules**

– These TaskMan options should be scheduled to run after hours when the fewest users are on the system.
– The associated bulletins must have an attached mail group so that someone can generate necessary reports.

- **Other Important Considerations**

MCP/TRICARE will not work correctly if the TaskMan options are not scheduled and running.
These options should be scheduled by the systems specialist only.

TASKMAN OPTIONS TO SCHEDULE AND FREQUENCY

CP ENROLLMENT BULLETIN Schedule: Daily

Manages and processes Enrollment transactions. Adjusts an enrollee's MCP status depending on the DEERS response received.

1. Changes Pending Enrollment MCP status to enrolled/ disenrolled or invalid enrollment/disenrollment
2. Disenrolls patients with a status of conditional enrollment 120 days after enrollment date.
3. Identifies expired enrollments, disenrolls the patient and sends a disenrollment transaction to DEERS as appropriate for the enrollment mode. Adjusts the PCM counts.
4. Identifies all active duty enrollees whose end enroll date the following month matches the day set in the MCP parameters (CHCS Version 4.5 only) and transmits an enrollment transaction to DEERS. If eligible, updates the end enrollment date.
5. Identifies all active-duty who have been enrolled at your site more than three years and sends a transaction to DEERS (CHCS Version 4.5). Updates enrollment end date.

CP NAS DAILY CLEANUP Schedule: Daily

1. Purges NAS data temporarily stored in CHCS.

CP NET HCP BULLETIN Schedule: Daily

1. Checks on inactivated MCP providers and generates CP HCP Inactivation bulletin.
2. Notifies mail group recipients to generate a discrepancy report.

CP NET POC BULLETIN Schedule: Daily

1. Checks on MCP inactivated places of care and generates the CP POC Inactivation bulletin.
2. Notifies mail group recipients to generate the Discrepancy Avoidance Report.

CP UIC ENROLLEE MAINTENANCE Schedule: Weekly

1. Checks the Unit ID Code entry in a patient's file anytime it is accessed.
2. Updates a MCP cross reference if the UIC has been changed or if the UIC code does not match a valid entry in the Unit Ship ID file.
3. Generates a bulletin to remind users to print the UIC Maintenance Report.

CP UPDATE ENR END DATE Schedule: Daily

1. Updates the end enrollment date for active-duty enrollees each time a DEERS eligibility transaction is performed in PAS/MCP.

CP UPDATE CANDIDATE FILE Schedule: Daily

1. Checks any changes and updates the Potential Candidate file for batch enrollments.

- **Data Entry Process**

All data entry must be made by the systems specialist only. Ordinary TRICARE users should not have access to schedule these options.

· **Functionality Interactions**

These TaskMan options are MCP-specific and do not affect other functionalities.

· **Troubleshooting**

If any of the processes such as enrollment tasks do not appear to be running, perform a FileMan inquiry into the Option file and look for a scheduled time. If no future time displays, the TaskMan option is not running. Call the system specialist

2.4 Mail Bulletins

Mail Group Setup

Menu Path: Systems Manager Menu (EVE) ® MM ® MGE ®
Enter name of the Mail Group (e.g., MCP ENROLLMENTS)

Bulletin Attachment

Menu Path: Systems Manager Menu (EVE) ® MM ® EBUL ®
Enter Bulletin name (e.g., CP BATCH PCM)

· **Required Fields**

Mail Group Name
Organizer
Type
Allow Self Enrollment?
Description

· **Application Description**

MCP Mail bulletins are system generated whenever a process occurs or fails to occur (e.g., batch enrollments completed, batch reassignment unsuccessful). The bulletins can be set up to go to one mail group or to separate mail groups depending on its utility. System personnel should set up the mail groups and attach the bulletins.

· **Business Rules**

- The bulletins must attach to a mail group.
- The bulletins are not division-specific.

· **Other Important Considerations**

Your MTF must decide whether to create one mail group for all bulletins or separate mail groups depending on the content of the bulletin.

Bulletins

CP AD BATCH ENR COMPLETE – States that the Batch enroll AD candidates option has been completed.

CP AD BATCH UPD COMPLETE – Notifies the mail group that the process for updating potential AD enrollment candidate file is complete.

CP AGREEMENT MODIFICATION – Notifies the mail group and the user who changed the agreement start date for an existing agreement.

CP BATCH IDENTIFY AD ENR – Notifies the mail group once the Identify Potential Active Duty Candidates job is completed (IPADC).
CP BATCH PCM – Notifies the group when a batch job reassigning beneficiaries from one PCM to another under the Batch PCM option is complete.
CP BATCH PCM ABORT – Notification that the batch job for reassigning beneficiaries from one PCM to another was unsuccessful.
CP BATCH DISEN COMPLETE – Notifies the user when the batch disenrollment is complete.
CP BATCH DISENROLL COMPLETE – Notifies that the process of changing from DEERS enrollment (full enrollment) to Local Empanelment mode is complete.
CP ENR DIV CHANGE – Notifies the user and mail group when the Change Enrolling Division option is complete. Used with DMIS realignment.
CP HCP INACTIVATION DATE – Generated daily to show any inactive providers, and serves as a reminder to check the Discrepancy Avoidance Report.
CP HCP INACTIVATION – Generated when a provider is inactivated or reactivated from one provider group or from all provider groups.
CP INVALID ENROLLMENT – Notification that beneficiaries were found to have discrepancies between DEERS and CHCS during an enrollment/disenrollment transaction. This bulletin recommends that the Enrollment/Disenrollment Discrepancy Report be printed to reserve and correct the discrepancies.
CP MULTIPLE BATCH PCM – Notifies a group when a batch job for reassigning beneficiaries from one PCM to multiple PCMs under the Batch PCM option has completed.
CP NEW UIC CODE – Notifies recipients that a new UIC code downloaded from DEERS does not match an entry in the Unit/Ship ID file. It recommends updating the file and editing the patient's mini registration.
CP PCM REACHED MAX CAPACITY – Generated during auto enrollment if the user accepts the defaulted PCM and that PCM has reached maximum overall capacity or maximum active-duty capacity. A warning displays for the user who may continue with the enrollment by assigning an alternate PCM.
CP POC INACTIVATION – Generated when a place of care is inactivated.
CP POC INACTIVATION DATE – Generated daily to show any discrepancies that exist for places of care that have been inactivated.
CP RECIPROCAL DISENR COMPLETE – Generated when the auto reciprocal disenrollments have completed and whether discrepancies have

been identified. The spool document of discrepancies is deleted after 14 days. A bulletin is also generated when no discrepancies are noted.
CP RENEW AGREEMENT BATCH PCM – Notifies the group that an agreement was renewed and the listed providers had their PCM patients reassigned.
CP RENEW AGREEMENT NON-PART – Notifies the group that an agreement was renewed and the listed providers are non-participants in the renewed agreement with PCM patients assigned.
CP RENEW AGREEMENT W-OUT BATCH – Notifies that an agreement was renewed and the listed providers have PCM patients that were not reassigned. They were not reassigned either because the user did not have the key to perform the function or the PCM was not selected to have their patients reassigned.
CP UIC MAINT RPT AVAIL – Notifies the group that the UIC Maintenance Report is available for printing. The report identifies those enrolled AD members whose UIC is invalid in CHCS or whose UIC has been changed.
CP UIC WITHOUT PCM – Generated during auto enrollment if the UIC matches an entry in the Unit/Ship ID file but has not been linked to a PCM (UIC/PCM link). A user may still complete the enrollment by directly assigning a PCM.
CP INACTIVATE UIC IN AUTO ENROLLMENT – Notification that an auto enrollment was performed for a patient whose UIC has been inactivated. It recommends that the patient's mini registration be updated.
CP BATCH RENEW COMPLETE – Notification that the process to batch renew enrollment has completed and to generate the Batch Renewal Disenrollment Roster.
CP BATCH DISEMPANEL COMPLETE – Notification that non-active-duty members have been disempaneled after switching from Local Empanelment mode to the DEERS Enrollment mode.
CP PARAMETERS – Notification that the dates to perform annual and monthly eligibility checks are incomplete in the MCP Parameters option.

- **Data Entry Process**

All data entry should be completed by a systems/DBA person.

- **Functionality Interactions**

None

- **Troubleshooting**

If mail groups are not receiving the bulletins, contact the system administrator.
If a report is not available that a bulletin indicated was ready, review whether the time to print has expired. The bulletin specifies the number of days on some reports within which a spooled report must be printed.

Section 3 Provider Network Management

3. PROVIDER NETWORK MANAGEMENT

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Introduction

The MCP functionality of CHCS enables online searches for the most cost-effective patient care. The MCP network is an area-wide health care delivery system based on enrolled beneficiaries and cooperative agreements between military hospitals and civilian health care providers (HCPs).

Provider network management is intended to accomplish the following:

- Document negotiated agreements with civilian providers that provide accessible and cost-effective health care
- Develop an integrated network of primary and specialty care providers.

The MCP software collects and maintains information for a comprehensive health care network to augment medical treatment facility (MTF) direct-care capabilities.

This network may include:

- PRIMUS/NAVCARE clinics
- Civilian and group providers/health maintenance organizations (HMOs).

The MCP provider network includes both MTF (internal) and civilian (external) HCPs, in addition to MTF-contracted providers.

Designated personnel create the structure for the provider network by entering group and individual provider information. This information comprises both group and individual profiles.

Definitions

Internal Providers - Internal providers are both military and civilian. Civilian providers have partnership agreements to provide care within the MTF. Whenever possible, internal providers are used.

External Providers - Civilians with agreements to deliver health care, at discounted rates, to Military Health Service System (MHSS) beneficiaries at the provider's place of care.

External providers are used when timely military care is unavailable. The agreements with external providers are negotiated to obtain the highest quality service for the lowest rate.

Non-Network Provider - A provider who is not a member of the network; i.e., has not signed a network agreement and does not offer a negotiated discount for services.

Exception Provider - A non-network provider who has been identified to give specialized treatment to an enrolled patient based on one of the following:

- **Only Service Available Provider.** A provider who offers a specialty or service unique to the area. Only service available (OSA) providers can be exception providers. They appear on picklists when searching by specialty and location.
- A provider who has previously provided care for a patient and disruption of that care would be detrimental to the patient.

A non-MTF provider group can be created for the exception provider.

Network - A group of individual providers, provider groups, and institutions or services that have an agreement with the MTF to provide services, at a discounted rate, to TRICARE-enrolled beneficiaries. This provider type includes MTF provider groups.

The Preferred Provider Organization (PPO) may also benefit non-enrolled patients. Non-enrolled patients may be booked to an MCP provider who charges a lesser rate than the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) allowable rate.

Valid network provider types

NGP - Network Provider Group (provider group only)
NPR - Network Individual Provider (individual providers)
NIS - Network Institution/Service (provider group only).

- **Non-Network**

These individual providers, groups, and institutions or services do not have agreements to provide services, at a discounted rate, to MCP-enrolled patients or as part of the PPO.

Beneficiaries may receive CHAMPUS-reimbursed services from non-network providers, if approved by the MTF.

Exception providers may be non-network providers.

Valid non-network provider types include the following:

XPR - Non-Network Provider (individual providers)
XGP - Non-Network Provider Group (provider group only)
XIS - Non-Network Institution/Service (provider group only).

- **Only Service Available**

These individual providers, provider groups, and institutions or services do not have an agreement to provide services at a discounted rate. However, the health care finder (HCF) may refer to these providers because they offer specialties or procedures not available within the network or through the non-network providers.

> **Note:** An exception provider may be an OSA provider or a non-network provider, but not both.

Valid OSA provider types include the following:

OPR - Only Service Individual Providers (individual providers)
OGP - Only Service Provider Group (provider group only)
OIS - Only Service Institution/Service (provider group only).

3.1 Group Profile/Agreements Enter/Edit (GNET)

Menu Path: PAS System Menu → M → PMCP → GNET

- **Required Fields**

MCP Provider Group Name

- **Application Description**

The Group Profile/Agreements Enter/Edit option allows you to associate places of care, agreements, and providers with a provider group. It allows you to edit or view the group profile for a selected provider group, and to enter, edit, or view associated clinic profiles for the places of care.

> **Note:** New MCP provider groups must first be created using the file and table build functions for MCP menu options. A group profile can be created only through the Group Enter/Edit option.

You may also add, edit, terminate, and/or renew group agreements. For any agreement, you may add, edit, and/or delete procedure and specialty exceptions, and add or edit primary care manager (PCM) enrollment mix data.

You may enter, edit, or view provider group member profiles. For a given provider group member, you may enter, edit, or delete data for provider agreements. For a given group agreement, you may indicate whether the member provider participates in it, edit the dates and discount rate for the provider, enter procedure and specialty exceptions, and add or edit PCM enrollment mix data, including PCM assignment limitations, age limitations, and comments.

You may also inactivate or reactivate a place of care within the group, a provider member within the group, or a provider member within a place of care, and print a Discrepancy Avoidance Report and/or the Enrollment Mix Discrepancy Report.

Descriptions of the capabilities within this option have been separated into the following actions:

Agreements
Providers
Inactivate/Reactivate

- **Data Entry Process**

Refer to Section 2.2.1 Enrollment File/Table Maintenance Menu (ETAB), for data entry details.

3.2 Individual Provider Profile/agreements Enter/Edit (INET)

Menu Path: PAS System Menu → M → PMCP → INET

- **Required Fields**

MCP Provider Name
MCP Group Name

Output Device

- **Application Description**

The Individual Provider Profile/Agreements Enter/Edit option allows you to enter or edit individual provider profile and agreement data for selected MCP providers. In addition, you can inactivate or reactivate MCP providers or the providers' places of care. A provider can also be added as a new member to an existing MCP provider group. When adding or editing places of care, you can use the Provider Profile Enter/Edit option to update provider profiles, since no appointments can be booked for the provider until Patient Appointment and Scheduling (PAS) provider profile information is entered.

- **Data Entry Process**

Refer to Section 2.2.2 Individual Provider Profile/Agreements Enter/Edit, for data entry details.

3.3 Modify Group Agreement Effective Date (MNET)

Menu Path: PAS System Menu → M → PMCP → GNET → MNET

- **Required Fields**

MCP Provider Group Name
MCP Agreement Type
New Agreement Effective Date

- **Application Description**

The Modify Group Agreement Effective Date option allows you to modify the effective date of an agreement for a provider group. The system produces an agreement history record for each modification. These records are numbered and sorted in chronological order. This option also allows you to view the agreement history records.

- **Data Entry Process**

Refer to Section 2.2.4 Outputs and Network Management Reports Menu (ONET), for data entry details.

3.4 Outputs & Network Management Reports (ONET)

Menu Path: PAS System Menu → M → PMCP → ONET

```
   GMRM   Group Management Reports Menu
   AMRM   Agreement Reports Menu
   MMRM   Miscellaneous Network Reports Menu

Select Outputs & Network Management Reports Menu Option:
```

Figure 3-1. Outputs & Network Management Reports Menu

3.4.1 Group Management Reports Menu (GMRM)

Menu Path: PAS System Menu → M → PMCP → ONET → GMRM

```
   1      Group Member Roster
   2      Provider Group Report
   3      Provider List by Specialty
   4      PCM Enrollment Mix Discrepancy Statistical Summary
   5      PCM Enrollment Mix Discrepancy Report

Select Group Management Reports Menu Option:
```

Figure 3-2. Group Management Reports Menu

3.4.1.1 Group Member Roster

Menu Path: PAS System Menu → M → PMCP → ONET → GMRM → 1

- **Required Fields**

  Provider group name
  Provider name
  Specialty name
  Agreement type
  Output device
  Start time

- **Application Description**

The Group Member Roster option allows you to print a roster listing MCP provider groups, MCP providers within groups, and specialties and agreements pertaining to the providers. You can selectively generate the roster for one, multiple, or all provider groups.

- **Use/Frequency**

This report should be run to verify that all groups have been set up and the correct group members identified. This report should be run when a group is added or updated to verify that a group has the correct members with the correct attributes.

Refer to Figure 3-2. Group Management Reports Menu, page 3-7.

3.4.1.2 Provider Group Report

Menu Path: PAS System Menu → M → PMCP → ONET → GMRM → 2

- **Required Fields**

Group Name
Place of Care
Agreement Type
Provider Name
Patient Type
Specialty/procedure code
Provide Type
Section
Output Device

- **Application Description**

The Provider Group Report option allows you to print a report by specified or selected MCP provider group(s) and section(s). You can print the report for one, multiple, or all provider groups. Within the selected group(s), you can specify the section(s) to print. This report lists most of the MCP data elements collected for a group or individual provider and should be used to validate the accuracy and completeness of the provider record.

After you select the group, select which of the following sections to print: group information, places of care, agreements and providers, PCMs, group-level exceptions, and individual provider exceptions. Each section requested is printed on a separate page.

- **Use/Frequency**

As needed. This report should be run whenever a provider, particularly a PCM, is updated in the file and table build functions. Use this report to validate the completeness and correctness of the total information set up for the provider. Use this report to verify that:

– All places of care have been set up and are activated

– Places of care are not duplicated

– Groups and their members are appropriately defined and activated

– All specialties are indicated for the provider and provider group

– Individual provider agreement start and stop dates are within the group agreement start and stop dates

– The group is designated as a PCM if any group member is a PCM

– PCM enrollment mixes/capacities are set up correctly

– PCM capabilities have been entered correctly at the group and group-member levels, including definition of the correct places of care and appropriate **specialties** indicated as primary care for the provider

– The maximum PCM capacities are set up consistently for the group and for each group member

– General verification of all provider data as needed.

Refer to Figure 2-112. Provider Group Report - Group Information.

3.4.1.3 Provider List by Specialty

Menu Path: PAS System Menu → M → PMCP → ONET → GMRM → 3

- **Required Fields**

  Provider type
  Specialty
  Provider
  Provider group
  Agreement type
  Output device
  Start time

- **Application Description**

The Provider List by Specialty option allows you to print reports listing providers by provider type and specialty. The report totals MCP providers by provider type and by specialty.

You can print reports for network providers, for one, multiple or all specialties, one, multiple or all MCP provider types, and by one, multiple or all specialties.

- **Use/Frequency**

As needed. This report should be run to determine if all specialties are appropriately covered by the network. The report allows you to evaluate the types of agreements in the network and the distribution across specialties, as well as expiration dates and discounts.

Refer to Figure 2-116. Provider List by Specialty.

3.4.1.4 PCM Enrollment Mix Discrepancy Statistical Summary

Menu Paths:

PAS System Menu → M → PMCP → ONET → GMRM → 4

PAS System Menu → M → OMCP → PRPT → 7

PAS System Menu → M → EMCP → OENR → PRPM → 7

- **Required Fields**

Group name
PCM
Output device

- **Application Description**

The PCM Enrollment Mix Discrepancy Statistical Summary option allows you to generate and print reports identifying PCMs whose patient loads exceed their PCM capacity for one or more beneficiary categories or who have beneficiaries assigned to them whose ages are outside of the PCM-assigned age-range preferences. The system allows you to sort by PCM or by group. Within each PCM or group, the system sorts by agreement. An asterisk (*) indicates the PCM beneficiary categories that have discrepancies, and the report displays the numeric values of the discrepancies.

The system allows you to sort by group or PCM and to select one, multiple, or all of the selected category. A group sort lists the groups alphabetically within each group, it lists the providers alphabetically. The report includes a statistical summary of the group's capacity and age-range preferences and associated patient load. It also gives the statistics for each of the providers within the selected group. A PCM sort lists alphabetically all PCMs who have discrepancies. The report includes a statistical summary of the PCM's capacity and age-range preferences and associated patient load. It also gives the statistics for each of the providers within the selected group. The report does not include individual or group providers who have no discrepancies.

- **Use/Frequency**

As needed.

Refer to Figure 2-117. PCM Enrollment Mix Discrepancy Statistical Summary.

3.4.1.5 PCM Enrollment Mix Discrepancy Report

Menu Paths:

PAS System Menu → M → PMCP → ONET → GMRM → 5

PAS System Menu → M → EMCP → OENR → PRPM → 8

PAS System Menu → M → EMCP → OENR → PRPM → 8

- **Required Fields**

Group name
PCM
Beneficiary category
Output device

Refer to Figure 2-118. PCM Enrollment Mix Discrepancy Report.

3.4.2 Agreement Reports Menu (AMRM)

3.4.2.1 Provider Alphabetic Agreement Roster

Menu Path: PAS System Menu → M → PMCP → ONET → AMRM → 1

- **Required Fields**

Provider type
Provider name
Provider group
Agreement type
Output device
Start time

- **Application Description**

The Provider Alphabetic Agreement Roster option allows you to print alphabetical lists of current provider agreements. This report includes provider, specialty, provider group, effective date, stop date, discount, and exceptions indicator.

You can select one, multiple, or all provider types for the roster. The roster sorts the agreements by provider type, provider name, and provider group; lists specialties for each provider; and totals agreements by provider type.

If you select network, the report is sorted by the three provider types that imply network membership: Network Individual Provider, Network Institution/Service, and Network Provider Group. Report data is the same as if selected by one, multiple, or all provider types.

- **Use/Frequency**

Run this report as needed, to evaluate the scope of the contracts available to support care in the network.

Refer to Figure 2-119. Provider Alphabetic Roster..

3.4.2.2 Specialty Provider Agreement Roster

Menu Path: PAS System Menu → M → PMCP → ONET → AMRM → 2

- **Required Fields**

Provider type
Specialty type
Agreement type
Provider name
Group name
Output device
Start time

- **Application Description**

The Specialty Provider Agreement Roster option allows you to print agreement rosters for all active network providers for One, Multiple, or All provider types by One, Multiple, or All specialties. Totals are provided for specialty for provider type.

For provider types that imply individuals, the roster lists the provider's group agreements and the associated effective dates, stop dates, discounts, and exceptions indicators. For provider types that imply groups, for each specialty, the roster lists the agreement, group, effective stop date, discount rate, and exceptions.

- **Use/Frequency**

This report should be run as needed to determine the total support available for a specialty and the projected agreement expiration dates of the providers supporting the specialty. Agreement expirations are listed by type of agreement.

Refer to Figure 2-120. Specialty Provider Agreement Roster.

3.4.2.3 Specialty Provider Agreement Summary

Menu Path: PAS System Menu → M → PMCP → ONET → AMRM → 3

- **Required Fields**

Provider type
Specialty
Output device
Start time

- **Application Description**

The Specialty Provider Agreement Summary option allows the you to print a summary report giving the number of agreements by provider type, provider specialty, and agreement type. Totals are given for agreements pertaining to a specialty and total agreements pertaining to a provider type. Grand totals are provided for the entire facility.

- **Use/Frequency**

This report should be run as needed, to determine the volume of agreements in effect on the report run date and the specialties and agreement types supported.

Refer to Section 2.2.4.2.4 #4 Discount Provider Agreement Roster.

3.4.2.4 Discount Provider Agreement Roster (obsolete under TRICARE)

Menu Path: PAS System Menu → M → PMCP → ONET → AMRM → 4

- **Required Fields**

  Provider type
  Specialty
  Discount
  Provider name
  Provider group
  Output device
  Start time

- **Application Description**

The Discount Provider Agreement Roster option allows you to print reports showing all active provider agreements by discount. It shows the total number of providers for each discount rate. The report is sorted by agreement type, provider type, provider specialty, and discount rate.

- **Use/Frequency**

Run this report to evaluate the savings realized by the provider network and the trends in discounting among network providers.

Refer to Figure 2-122. Discount Provider Agreement Roster.

3.4.2.5 Expiration Date Provider Agreement Roster

Menu Path: PAS System Menu → M → PMCP → ONET → AMRM → 5

- **Required Fields**

  Agreement type
  Date range
  Output device
  Start time

- **Application Description**

The Expiration Date Provider Agreement Roster option allows you to print reports of MCP provider agreements which expire within a specified date range for One, Multiple, or All agreement types, sorted alphabetically by provider, and within provider, by provider group. The report displays provider agreement and specialty data. The end of the report shows subtotals for the agreement types and an overall total for all agreements on the report.

- **Use/Frequency**

Monthly or as needed to determine when agreements are about to expire.

Refer to Figure 2-124. ZIP Code Agreement Roster.

3.4.2.6 ZIP Code Agreement Roster

Menu Path: PAS System Menu → M → PMCP → ONET → AMRM → 6

- **Required Fields**

ZIP code
Specialty
Provider group
Provider
Agreement type
Output device
Start time

- **Application Description**

The ZIP Code Agreement Roster option allows you to print rosters listing and totaling providers by ZIP code and specialty. You can generate a roster for a single ZIP code or a ZIP code combination, for one, multiple or all specialties, and either for all providers or for PCMs only.

The roster is sorted by ZIP code, provider specialty, provider name, provider group, agreement type, and agreement effective date.

- **Use/Frequency**

Monthly or as required to identify the geographic distribution of network providers and specialties.

Refer to Figure 2-124. ZIP Code Agreement Roster.

3.4.3 Miscellaneous Network Reports Menu (MMRM)

```
   1      Provider Batch Address Labels - Build Utility
   2      Provider Batch Address Labels - Print Utility
   3      Discrepancy Avoidance Report

Select Miscellaneous Network Reports Menu Option:
```

Figure 3-3. Miscellaneous Network Reports Menu (MMRM)

3.4.3.1 Provider Batch Address Labels - Build Utility

Menu Path: PAS System Menu → M → PMCP → ONET → MMRM → 1

- **Required Fields**

Provider name
Agreement type
Specialty
Expiration
Output device

- **Application Description**

The Provider Batch Address Labels - Build Utility option allows you to select providers by provider name, agreement type, specialty, or expiration date to generate provider payment address labels. You can specify one, multiple, or all providers; one, multiple, or all agreement types; and one, multiple, or all specialties.

Note: When selecting providers by agreement type, you must also specify an expiration date. The system only selects providers who participate in a specified agreement that expires on that specified date.

When specifying selection by an expiration date without selecting agreements, the system selects providers who participate in any agreement that expires on the specified date.

When you specify a provider for the search, the system searches the Provider file by the specified provider name to generate labels.

Based on the search criteria entered, the system searches the MCP Provider file for all providers that meet the specified search criteria.

The system places providers who meet the search criteria during the above search and have complete payment address information in a global file. This file may be used to generate and print labels using the Provider Batch Address Labels - Print Utility option.

The system places providers who meet the search criteria during the above search but have incomplete (missing) payment address information in a global file. This file may be generated and printed using the Incomplete Provider Address Report option.

Refer to Figure 3-3. Miscellaneous Network Reports Menu (MMRM), page 3-17.

- **Use/Frequency**

As needed.

3.4.3.2 Provider Address Labels - Print Utility

Menu Path: PAS System Menu → M → PMCP → ONET → MMRM → 2

- **Required Fields**

User name
Output device

- **Application Description**

The Provider Batch Address Labels - Print Utility option allows you to print provider address labels which were compiled using the Provider Batch Address Labels - Build Utility option.

The system allows you to display a picklist of all global label batches compiled at various times for a specific user or for all users. After you select a batch from the picklists, you can print the labels, delete the batch, or view the search criteria that were used to compile the labels.

You can print a complete batch of labels or a subset. If you print a subset, the system prompts you for the number of labels to print, then prints that number of labels in alphabetical order. After the system prints a label, that label is deleted and cannot be reprinted unless the provider batch address labels are rerun. If all the labels in the batch are printed, the batch is no longer accessible through this option. Batches of labels remain on the system until all the labels have been printed or until a user deletes the batches through this option.

3.4.3.3 Discrepancy Avoidance Report

Menu Path: PAS System Menu → M → PMCP → ONET → MMRM → 3

- **Required Fields**

  Place of care
  Provider group name
  Provider name

- **Application Description**

The Discrepancy Avoidance Report option allows you to generate a report of the groups, providers, and patients in a given place of care or a provider that needs to be changed before the place of care or provider may be inactivated.

Before any place of care can be inactivated, any booked appointments, booked appointments related to referrals, and/or any patients assigned to the place of care as the PCM need to be resolved. The system also issues a warning if you try to inactivate the only place of care associated with an individual provider.

If you generate this report for a **place of care**, you can choose one of three selection criteria:

1. All providers in all groups
2. A single group
3. A single provider in a single group.

The report consists of four sections. Each section is sorted first by groups to which the place of care belongs, then by providers within the group and place of care. The sections contain the following data:

1. Patients assigned to providers as PCMs
2. Patients having appointments with and referrals to providers
3. Patients having Wait List requests for providers
4. Providers in each group.

If you generate this report for a **provider**, you can choose one of two selection criteria:

1. All groups
2. Selected groups.

The report consists of four sections. Each section is sorted first by groups to which the provider belongs, then by places of care for the provider within the group. The sections contain the following data:

1. Patients assigned to the provider as a PCM
2. Patients having appointments with and referrals to the provider
3. Patients having Wait List requests for the provider
4. Places of care in each group.

You can also generate this report from those options which perform inactivations and reactivations:

1. The Group Profile/Agreements Enter/Edit option

a. A place of care can be inactivated from a group

b. A place of care can be inactivated from a provider

c. A provider can be inactivated from a group

2. The Individual Provider Profile/Agreements Enter/Edit option

a. A place of care can be inactivated from a provider

b. A provider can be inactivated from a group

3. The Provider Enter/Edit option

a. A provider can be inactivated from all of MCP.

- **Use/Frequency**

Run this report as required to identify the following in order to inactivate a provider or place of care:

– Beneficiaries whose referrals or appointments may need to be rescheduled

– Enrollees who may need to be reassigned to another PCM

– Wait List requests that may need to be assigned to another provider or place of care

– Places of care that may need to be inactivated

– Provider members of the group.

Refer to Figure 2-125. Discrepancy Avoidance Report.

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Section 4 DEERS Functions and Processes

4. DEERS FUNCTIONS AND PROCESSES

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Introduction

The Defense Eligibility Enrollment Reporting System (DEERS) interface is available to CHCS functionality upon demand.

4.1 DEERS Check (Enrollment/Family Member Screens)

Menu Paths:

PAS System Menu → M → EMCP → EENR

PAS System Menu → M → EMCP → RENR

- **Required Fields**

  Patient name
  Sponsor name

- **Application Description**

The DEERS eligibility check (Enrollment/Family Member screens) is invoked for patients being processed through enrollment functionality only (the Enrollment Enter/Edit (EENR) or Reciprocal Disenrollment Processing (RENR) options). The DEERS eligibility check is required to determine a selected patient's eligibility for direct care, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and Medicare. It also informs you of the patient's enrollment status and participation in other programs, such as CHAMPUS Dental and Uniformed Services Treatment Facilities (USTF) enrollees.

Enrollment processing should include both the initial patient and other family members. The family screen method allows you to rapidly process all selected family members through DEERS and determine the eligibility for each. The system determines the family member by comparing sponsor Social Security number (SSN).

After the DEERS check, the system displays the Demographics Display screen for continued processing. Refer to Figure 4-1. Demographics Display Screen, page 4-2.

```
                              DEMOGRAPHICS DISPLAY

                  Name: PEARL,ZACHARY N.      FMP/SSN: 20/569-69-4415
      Patient Category: USN ACTIVE DUTY           DDS:
          Patient Type:                           Sex: MALE
            MCP Status:                        DOB/Age: 12 Jun 1975/26Y
                   ACV:                        DMIS ID:
           Direct Care:                       Medicare:

          Sponsor Name: PEARL,ZACHARY N.         Rank: CHIEF PETTY OFFICE
          Station/Unit: W. R. MED HOLD PP         DSN: 331
          Home Address: 1020 NEWPORT DRIVE
                  City: HAMPTON                 State: VIRGINIA
              ZIP Code: 23665              Home Phone: 974-2333
            Duty Phone: 804-555-4993       Work Phone: 804-555-4993
  Registration Comment: new patient
Last Registration Date: 21 Jun 2001@152316
Outpatient Record Room: MEDICAL RECORDS FILE ROOM
       MCP Enroll Date:               End Enroll Date:
  Primary Care Manager:                    PCM Phone:
           Primary OHI: NOT ASSIGNED       Case Mgmt:

Select (F)ull, (M)ini, (E)nrollment, (N)ew Patient, or (Q)uit DEMOGRAPHICS: Q//
```

Figure 4-1. Demographics Display Screen

If the DEERS link is down and no DEERS check has been made within the past five days, the system displays a warning/information message. If you continue the enrollment process, the patient's enrollment status is set to Pending until a DEERS check can be completed.

If the patient is ineligible, you can enter an override code to continue enrollment processing. Refer to Appendix A, DEERS Eligibility Override Code Picklist, for a list of possible override codes. However, an override is not recommended since DEERS will reject the enrollment of an ineligible beneficiary.

Each DEERS check compares CHCS data to DEERS data through the interface linking the two systems, and displays any discrepancies that need to be resolved.

- **Data Entry Process**

Check DEERS eligibility during enrollment or reciprocal disenrollment

Access the Enrollment Family Member screen

Select the patient name

View family members

Select other family members to process

Complete the DEERS check

Access the Enrollment/Family Member screen

Select the patient name

The Enrollment/Family Member screen displays from either the Enrollment Enter/Edit (EENR) option or the Reciprocal Disenrollment Processing (RENR) option. The system displays the name of the patient identified and requests confirmation of the patient name and sponsor name prior to continuing with the DEERS check. Refer to Figure 4-2. Select Patient Name Prompt, page 4-4. You can either confirm and continue, or return to the *Select*

PATIENT NAME prompt to specify another patient name. If the patient is not registered in CHCS, enter patient identification data into CHCS.

```
Select PATIENT NAME: MOREHOUSE,JERALD     20/477-23-3789 01 Apr 1970 M
         OK? YES//   (YES)
SPONSOR NAME: MOREHOUSE,JERALD//
```

Figure 4-2. Select Patient Name Prompt

CHCS uses the sponsor SSN to request a family member response from DEERS. The Family Member screen displays today's DEERS eligibility data for each family member. Refer to Figure 4-3. Family Member Screen, page 4-4. Then the system automatically performs a DEERS check. If the patient has been determined to be ineligible for this enrollment, enter an override code to continue enrollment, or abort from the enrollment process and return to the *Select PATIENT NAME* prompt. Refer to Figure 4-8. DEERS Eligibility Data, page 4-12. An override is not recommended, since DEERS will reject the enrollment of an ineligible beneficiary. Usually, beneficiaries are required to correct their data in DEERS before they can enroll. DEERS sends data for up to 23 family members.

```
                              FAMILY MEMBER SCREEN
     Patient Name: MOREHOUSE,JERALD                 FMP/SSN: 20/577-23-3789
              DOB: 01 Apr 1970
     Sponsor Name: MOREHOUSE,JERALD              Sponsor SSN: 577-23-3789
  Elig Start Date: 09 Feb 1992                 Elig End Date: INDEFINITE
--------------------------------------------------------------------------------
  Name                 Sex  DOB          DDS  ACV  Dir  Med DMIS  ACV Start/End
_______________________________________________________________________________
_
  MOREHOUSE,JERALD     M    01 Apr 1970  20    A   E    N   1000  01Jun95-INDEF
  MOREHOUSE,MARYANNE   F    01 Aug 1993   1    N   E    N
  MOREHOUSE,IRVING     M    01 Jul 1996   2    E   E    N   1000  01Jun97-
31Dec97
  MOREHOUSE,KATHRYN    F    09 Apr 1969  30    N   E    N   1000  01Jun97-
31Dec97


MOREHOUSE,JERALD is this the patient you are enrolling? Yes//
```

Figure 4-3. Family Member Screen

[NAME] is this the patient you are enrolling? Yes//

Press <Return> to accept the "Yes" default.

View family members

You can select other family members, one at a time, to process from the list of family members displayed. Before you select a family member for enrollment, you can view family members currently registered in CHCS. Refer to Figure 4-4. Family Member Screen - Processing, page 4-5.

```
                              FAMILY MEMBER SCREEN
     Patient Name: MOREHOUSE,MARYANNE                FMP/SSN: 01/577-23-3789
              DOB: 01 AUG 1993
     Sponsor Name: MOREHOUSE,JERALD              Sponsor SSN: 577-23-3789
  Elig Start Date: 09 Feb 1992                 Elig End Date: INDEFINITE
--------------------------------------------------------------------------
Name                  Sex  DOB          DDS  ACV  Dir  Med DMIS  ACV Start/End
_____________________________________________________________________________
_
  MOREHOUSE,JERALD     M    01 Apr 1970  20    A   E    N   1000  01Jun95-INDEF
  MOREHOUSE,MARYANNE   F    01 Aug 1993   1    N   E    N
  MOREHOUSE,IRVING     M    01 Jul 1996   2    E   E    N   1000  01Jun97-
31Dec97
  MOREHOUSE,KATHRYN    F    09 Apr 1969  30    N   E    N   1000  01Jun97-
31Dec97

 _____________________________________________________________________________
 Use SELECT key to select Other Family Member(s) to process, or use F9 key
to view family members currently registered in CHCS
```

Figure 4-4. Family Member Screen - Processing

Position the cursor next to a family member name that you want to view, then press <F9>.

The system displays the CHCS Family Member screen. Refer to Figure 4-5. CHCS Family Member Screen, page 4-6.

```
                              CHCS FAMILY MEMBER SCREEN
     Patient Name: MOREHOUSE,MARYANNE                FMP/SSN: 01/577-23-3789
              DOB: 01 AUG 1993
     Sponsor Name: MOREHOUSE,JERALD               Sponsor SSN: 577-23-3789
  Elig Start Date: 09 Feb 1992                 Elig End Date: INDEFINITE
-------------------------------------------------------------------------
Name                  Sex  DOB          DDS  ACV  Dir  Med DMIS  ACV Start/End
_________________________________________________________________________
_
  MOREHOUSE,JERALD     M    01 Apr 1970  20    A   E    N   1000  01Jun95-INDEF
  MOREHOUSE,MARYANNE   F    01 Aug 1993   1    N   E    N
  MOREHOUSE,IRVING     M    01 Jul 1996   2    E   E    N   1000  01Jun97-
31Dec97
  MOREHOUSE,KATHRYN    F    09 Apr 1969  30    N   E    N   1000  01Jun97-
31Dec97


_________________________________________________________________________
 Use Prev Screen/Next Screen keys to view family members currently registered
 in CHCS, or Press <RETURN> to continue
```

Figure 4-5. CHCS Family Member Screen

Press <Return> to continue.

The system redisplays the Family Member screen where you can select the family member you want to process next. Refer to Figure 4-6. Family Member Screen (Second Family Member), page 4-7.

Select other family members to process

```
                               FAMILY MEMBER SCREEN
     Patient Name: MOREHOUSE,MARYANNE                FMP/SSN: 01/577-23-3789
              DOB: 01 Aug 1993
     Sponsor Name: MOREHOUSE,JERALD               Sponsor SSN: 577-23-3789
  Elig Start Date: 09 FEB 1992                 Elig End Date: INDEFINITE
-------------------------------------------------------------------------
--
  Name                  Sex  DOB          DDS  ACV  Dir  Med DMIS  ACV
Start/End
_________________________________________________________________________
_
+*  MOREHOUSE,MARYANNE  F    01 Aug 1993   1    N   E    N
    MOREHOUSE,IRVING    M    01 Jul 1996   2    E   E    N  1000  01Jun97-
31Dec97
    MOREHOUSE,KATHRYN   F    09 Apr 1969  30    N   E    N  1000  01Jun97
31Dec97
_________________________________________________________________________
```

```
  MOREHOUSE,MARYANNE  01/577-23-3789  01 Aug 1993  F
Family member match found in CHCS, is this the correct family member?
```

Figure 4-6. Family Member Screen (Second Family Member)

1. Position the cursor next to the family member(s) you want to process next then press <Select>.

2. Enter "Y" at the *Family member match found in CHCS, is this the correct family member?* prompt.

3. If you enter "N" the system prompts, *Are you adding 'MOREHOUSE,MARYANNE' as a new PATIENT?* If you enter "Y," the system displays the Mini Registration screen and allows you to register this family member in CHCS.

Note: If a discrepancy exists between CHCS and DEERS for the beneficiary, the CHCS/DEERS Discrepancy Data screens display. Refer to Figure 4-15. Initial CHCS/DEERS Discrepancy Data Screen, page 4-26.

The system processes each family member selected for registration, in turn, but not for enrollment. To enroll family members, select F(a)mily on the action bar.

Complete the DEERS check

An individual DEERS check is performed on the family members only if this is a new registration.

If the DEERS check determines data discrepancies between the CHCS and DEERS files for a selected family member, the CHCS/DEERS discrepant data check is invoked. Refer to Section 4.5 CHCS/DEERS Discrepancy Data Check, page 4-21.

Additionally, if the system determines that the selected family member is currently enrolled in USTF, a warning message displays and the beneficiary cannot be enrolled. Refer to Section 4.4 Enrollees of USTF Managed Care Program, page 4-19.

Note: DEERS and CHCS communicate both interactively, and through transactions, such as eligibility, registration, address updates, and enrollment transactions. After the enrollment data is filed in CHCS, CHCS computes the alternate care value (ACV) from the CHCS patient category and sends an enrollment transaction to DEERS (depending on enrollment mode for non-active-duty enrollees). The enrollment status is usually set to pending enrollment or conditional enrollment. When DEERS returns the response transaction to CHCS , MCP updates the status appropriately.

If DEERS returns a nonsuccessful discrepancy response to CHCS, the Managed Care Program (MCP) status of the enrollment is changed from Conditional Enrollment or Pending Enrollment to Invalid Enrollment. Conversely, if DEERS returns a successful response to CHCS, an enrollment with an MCP status of Invalid Enrollment remains as originally initialized.

A Pending Enrollment is either an enrollment that has not yet been received by DEERS or and enrollment with a future enrollment date; an enrollment with Pending Enrollment status acquires a status of Enrolled on that date upon confirmation by DEERS.

After completing an enrollment or disenrollment transaction in CHCS, the system sends an enrollment or disenrollment transaction to DEERS as a background process for active-duty and Medicare patients while in Local Empanelment mode and for all patients when in DEERS Enrollment mode. The enrollment mode has no effect on active-duty or Medicare enrollments.

After completing all DEERS checks and registration for all selected family members, the system returns to the Demographics Display screen of the option in process (Enrollment Enter/Edit or Reciprocal Disenrollment Processing option). To enroll the family members, select F(a)mily from this action bar.

4.2 DEERS Check (Non-Enrollment/Individual Screens)

Menu Paths:

PAS System Menu → M → HMCP → PHCF

PAS System Menu → M → HMCP → AHCF

PAS System Menu → M → HMCP → NHCF

PAS System Menu → M → NMCP

PAS System Menu → M → IMCP → NNAS

PAD System Menu → ROM → DER

PAS System Menu → M → RMCP → RREG → DRDM

PAS System Menu → M → EMCP → IENR

PAS System Menu → CLERK → ROM → DRDM

PAS System Menu → EMER → RER → 2

(and any other menu where you must register a new patient)

- **Required Fields**

  Patient name
  Sponsor name

- **Application Description**

The DEERS eligibility check (Non-Enrollment/Individual screens) may be invoked automatically by CHCS or requested for individual patients. The DEERS check determines the patient's eligibility for direct care, CHAMPUS, and Medicare. It also informs you of the patient's enrollment status and participation in other programs, such as CHAMPUS Dental and USTF.

After you perform a DEERS eligibility check, you may access up to 10 segments of the patient's historical DEERS eligibility information, and view and correct existing

discrepancies between DEERS data stored in CHCS and the data currently residing in the DEERS data base. Refer to Section 4.5 CHCS/DEERS Discrepancy Data Check, page 4-21.

Note: From the individual eligibility request options, a Family Member screen response results, as the first screen in the Individual DEERS check, under the following conditions:

1. The user requests an interactive DEERS check; Family Member Prefix (FMP) equals 99 on a sponsor request
2. The DEERS data base does not contain a direct match to a patient; the date of birth (DOB) does not match and no corresponding DEERS dependent suffix (DDS) is available on CHCS
3. Individuals within the family have the same date of birth (as in the case of twins)
4. The check is automatically performed in enrollment processing.

The Family Member screen allows you to view the family members and select the family member to process. CHCS then requests an individual eligibility check that includes the historical eligibility data for the selected family member.

- **Data Entry Process**

Request a DEERS check

Access the *Select Patient Name* prompt

Select the patient name

Display the Family Member screen from DEERS

Override ineligibility

View more DEERS data

View historical DEERS data

Print DEERS data

Access the Select Patient Name prompt

All menu paths previously listed in this section lead to the *Select Patient Name* prompt.

Select the patient name

Display the Family Member screen from DEERS

If the DEERS request was initiated by an FMP=99 code, if the DEERS data base does not contain a direct match to the patient-specified DOB, and no corresponding DEERS DDS is available on CHCS, or if individuals within the same family have the same date of birth (as in the case of twins), the system displays the Family Member screen from DEERS and allows you to select the correct patient to process for the DEERS eligibility check. Refer to Figure 4-7. Family Member Screen, Two Members with Same DOB, page 4-11.

```
                              FAMILY MEMBER SCREEN
    Patient Name: PEARL,ALAN N                        FMP/SSN: 20/469-69-4415
             DOB: 25 Sep 1973
    Sponsor Name: PEARL,ALAN N                    Sponsor SSN: 469-69-4415
 Elig Start Date: 01Jun95                       Elig End Date: INDEFINITE
--------------------------------------------------------------------------------
--
  Name                 Sex  DOB          DDS  ACV  Dir  Med  DMIS  ACV Start/End
_____________________________________________________________________________
  PEARL,ALAN N         M    25 Sep 1973  20   N    E    N    1000  01Jun95-INDEF
  PEARL,ALICE N        F    20 Nov 1974  30   C    E    N    1000  01Jun97-
31Dec97
  PEARL,ARNOLD N       M    03 Jan 1994   1   C    E    N    1000  01Jun97-
31Dec97
  PEARL,ALEXANDER E    M    12 Mar 1996   4   E    E    N    1000  01Jun97-
31Dec97
  PEARL,ANTHONY E      M    11 Mar 1995   2   E    E    N    1000  01Jun97-
31Dec97
  PEARL,AMANDA E       F    11 Mar 1995   3   E    E    N    1000  01Jun97-
31Dec97


_____________________________________________________________________________
Use SELECT key to select Patient for an individual eligibility check.
Use F9 key to view current patient eligibility or
Press RETURN to continue.
```

Figure 4-7. Family Member Screen, Two Members with Same DOB

Position the cursor beside the patient name you want to process, then press <Select>.

The system displays the DEERS Eligibility Data screen. Refer to Figure 4-8. DEERS Eligibility Data, page 4-12.

Override Ineligibility

If the patient is ineligible, you can enter an override code to continue, or abort the process and return to the *Select PATIENT NAME* prompt. Refer to Appendix A, DEERS Eligibility Override Code Picklist, for a list of possible override codes.

```
                              DEERS ELIGIBILITY DATA
                  Name: PEARL,ERIC                  FMP/SSN: 05/469-69-4415
     Patient Category: USN ACTIVE DUTY                    DDS:
               DOB/Age: 15 Jun 2001/                      Sex: MALE
_____________________________________________________________________________
                     NAME:
                      SEX:                                      DOB: 25 Sep 1973
                      DDS:                             Sponsor SSN: 469-69-4415
                      ACV:
          ACV Start Date:                              Region Code:
                  DMIS ID:
  Care Authorization PH#:                             PCM Location:
             Sponsor Rank:
              Sponsor UIC:
              Direct Care: NOT ELIGIBLE                   Medicare:
Dir Care Elig Start Date:                              CHAMPUS:
  Dir Care Elig End Date:
  Eligibility End Reason:

                                      BRAC Pharmacy Eligibility:
_____________Patient Ineligible. Enter Override to continue_____________
Select to (V)iew more DEERS data,(H)istorical DEERS(O)verride Ineligibility,
       (P)rint, or (Q)uit: O//

Do you want to Override the DEERS Ineligibility and continue? No//

Select DEERS ELIGIBILITY OVERRIDE CODE:
```

Figure 4-8. DEERS Eligibility Data

1. Press <Return> to accept the default (O)verride Ineligibility action.

2. Enter "Y" at the *Do you want to Override the DEERS Ineligibility and continue? No//* prompt.

3. Enter the appropriate DEERS Eligibility Override Code at the *Select DEERS ELIGIBILITY OVERRIDE CODE* prompt.

Note: The data displayed is from the DEERS data base. Refer to Figure 4-8. DEERS Eligibility Data, page 4-12.

You should not override an ineligibility since DEERS will reject enrollment of an ineligible beneficiary. Usually the beneficiaries are asked to correct their eligibility in DEERS.

View more DEERS data

The action bar on the DEERS Eligibility Data screen also allows you to (V)iew more DEERS data, view (H)istorical DEERS data, or (P)rint DEERS data. Refer to the action bar shown in Figure 4-8. DEERS Eligibility Data, page 4-12. If you choose (V)iew more DEERS data the system displays the DEERS Eligibility Data (View Action) screen. Refer to Figure 4-9. DEERS Eligibility Data (View Action), page 4-13.

```
                          DEERS ELIGIBILITY DATA
                  Name: PEARL,ERIC              FMP/SSN: 05/469-69-4415
       Patient Category: USA FAM MBR AD             DDS: 20
                DOB/Age: 01 Apr 1970/26Y            Sex: MALE
_____________________________________________________________________________
   CHAMPUS Dental Flag:
     Dental Start Date:                          Dental End Date:
     Date Last Updated:                          Panograph Date:
             NAS Flag:                              Organ Donor: YES
  Reportable Disease                                        DNA:
  Database (RDDB) Date:
       Date of Request: 21 Jun 2001@152350
_____________________Patient Ineligible. Enter Override to continue_______
  Press <RETURN> to continue
```

Figure 4-9. DEERS Eligibility Data (View Action)

Press <Return> to continue.

The system redisplays the DEERS Eligibility Data screen and action bar. Refer to Figure 4-8. DEERS Eligibility Data, page 4-12.

View historical DEERS data

Choose the (H)istorical DEERS action to display up to 10 segments of the historical DEERS eligibility data. Refer to Figure 4-10. Historical DEERS Eligibility Data Screen, page 4-14.

```
                    HISTORICAL DEERS ELIGIBILITY DATA
                  Name: MOREHOUSE,JERALD            FMP/SSN: 20/577-23-3789
         Patient Category: USA ACTIVE DUTY OFFICER           DDS: 20
                  DOB/Age: 01 Apr 1970/26Y                   Sex: MALE

_____________________________________________________________________________
    Period               Direct Care      CHAMPUS          Medicare        ACV

_____________________________________________________________________________
    Date of Request:   04 Dec 1996@113836
    01 Jan 95             ELIGIBLE        NOT ELIGIBLE     NOT ELIGIBLE     N
    01 Mar 95

    02 Mar 95             ELIGIBLE        NOT ELIGIBLE     NOT ELIGIBLE     A
    05 Apr 95

    06 Apr 95             ELIGIBLE        NOT ELIGIBLE     NOT ELIGIBLE     N
    14 Nov 95

    15 Nov 95             ELIGIBLE        NOT ELIGIBLE     NOT ELIGIBLE     A
+   29 Nov 95

_____________________________________________________________________________
 Use the PrevScreen and Next Screen to view more data or
 Press <RETURN> to continue
```

Figure 4-10. Historical DEERS Eligibility Data Screen

The sample screen is for an active-duty patient with extensive historical DEERS data. The plus (+) at the bottom of the middle screen indicates that additional data can be displayed by pressing <Prev Screen> or <Next Screen>.

After completing the individual DEERS eligibility/enrollment, the system automatically returns to the point of entry of the option in process (normally the Demographics Display screen).

Print DEERS data

If you choose (P)rint DEERS data, you can print the DEERS Check information and the historical data. Refer to Figure 4-10. Historical DEERS Eligibility Data Screen, page 4-14.

4.3 Current DEERS Eligibility Display

Menu Paths:

PAS System Menu → M → HMCP → PHCF

PAS System Menu → M → HMCP → AHCF

PAS System Menu → M → HMCP → NHCF

PAS System Menu → M → NMCP

PAS System Menu → M → EMCP → EENR

PAS System Menu → M → EMCP → RENR

PAS System Menu → M → IMCP → NNAS

PAD System Menu → ROM → FRG*

PAD System Menu → ROM → MRG*

PAD System Menu → ADT → ADM*

* Only when processing a new patient.

- **Application Description**

The Current DEERS Eligibility Display screen displays when the patient being processed has had a DEERS check performed within the last five days. The Current DEERS Eligibility Display screen displays data stored in the CHCS database from the latest eligibility check and may not reflect the patient's most current DEERS eligibility data. Within enrollment, the system prompts to request the newest eligibility data from DEERS giving current enrollment status. Thus, the five-day eligibility reflects the patient's pre-enrollment status.

- **Required Data**

Patient name
Sponsor name

- **Data Entry Process**

Verify current DEERS eligibility

Access the *Select PATIENT* prompt through one of the above-listed menu paths

Select the patient name

Display five-day eligibility information

Display Current DEERS Eligibility second screen

Access the *Select PATIENT* prompt through one of the above-listed menu paths

Select the patient name

Display five-day eligibility information

If a DEERS check has been performed on the selected patient within the past five days, the Current DEERS Eligibility screen displays the data from that transaction.

Refer to Figure 4-11. Current DEERS Eligibility, page 4-17. The date of request on this screen indicates the date the eligibility check was received from DEERS. Consult this date to determine whether the DEERS check should be repeated to obtain more recent information.

```
                          CURRENT DEERS ELIGIBILITY
             Name: MOREHOUSE,KATHRYN            FMP/SSN: 30/577-23-3789
    Patient Category: USA FAM MBR AD                    DDS: 30
              DOB/Age: 09 Apr 1969/26Y                  Sex: FEMALE
_____________________________________________________________________________
           Sponsor Rank: CAPTAIN
            Sponsor UIC: 31127-NAVCRUSERVDET HONOLULU
                DMIS ID: 6501-TRICARE
                    ACV: E-MCP ENROLLED/DIR.  CARE CHAMPUS ELIGIBLE
         ACV Start Date: 01 Jul 1995            Region Code: 02
  Care Authorization PH#: 619-555-7526         PCM Location: CONTRACT
            Direct Care: ELIGIBLE                 Medicare: NOT ELIGIBLE
Dir Care Elig Start Date: 09 Feb 1992              CHAMPUS: ELIGIBLE
  Dir Care Elig End Date: INDEFINITE
  Eligibility End Reason: U-Not Predictable

                                  BRAC Pharmacy Eligibility: NOT ELIGIBLE
          Override Code:
        Date of Request: 04 Dec 1996@1307
_____________________________________________________________________________
Select to (V)iew more DEERS data, (P)rint, (R)epeat DEERS check, (C)ontinue,
       or (Q)uit: C//
```

Figure 4-11. Current DEERS Eligibility

The Current DEERS Eligibility action bar includes the following actions:

- (V)iew more DEERS - Displays a second screen containing the remainder of the DEERS data for the selected patient. Refer to Figure 4-12. Current DEERS Eligibility, Second Screen, page 4-18. After viewing, press <Return> to return to the screen and action bar. Refer to Figure 4-11. Current DEERS Eligibility, page 4-17.

- (P)rint - Prints a copy of the data on both the initial and second Current DEERS Eligibility screen. Enter a printer name and press <Return> at the *RIGHT MARGIN: 80//* prompt. Refer to Figure 4-13. Current DEERS Eligibility Printout, page 4-19. Press <Return> at the *Select DEVICE* prompt to display, the first screen. Press <Return> to view the second screen.

  Following printing, the system returns to the initial Current DEERS Eligibility screen and action bar.

- (R)epeat DEERS check - Invokes a new on-line DEERS check for the patient. DEERS must be on-line to perform this action. After you invoke the DEERS check, the system goes to the next action within the option being processed. This action displays only for a new, not an existing enrollment.

- (C)ontinue - Default action. The system goes to the next action within the option being processed.

– (Q)uit - Exits the option without further processing.

Display Current DEERS Eligibility, second screen

```
                          CURRENT DEERS ELIGIBILITY
             Name: MOREHOUSE,KATHRYN            FMP/SSN: 30/577-23-3789
     Patient Category: USA FAM MBR AD                   DDS: 30
              DOB/Age: 09 Apr 1969/26Y                  Sex: FEMALE

_____________________________________________________________________________
  CHAMPUS Dental Flag: 0-NO COVERAGE
    Dental Start Date:                          Dental End Date:
    Date Last Updated: 14 Aug 1995               Panograph Date:
            NAS Flag: YES                           Organ Donor: YES
Reportable Disease                                        DNA: YES
Database (RDDB) Date:
     Date of Request:

_____________________________________________________________________________
Press <RETURN> to continue
```

Figure 4-12. Current DEERS Eligibility, Second Screen

Press <Return> after viewing this screen. You return to the original DEERS Eligibility screen. Refer to Figure 4-11. Current DEERS Eligibility, page 4-17.

```
                        CURRENT DEERS ELIGIBILITY
                   Personal Data - Privacy Act 1974 (PL-93-579)

                Name: MOREHOUSE,KATHRYN            FMP/SSN: 30/577-23-3789
     Patient Category: USA FAM MBR AD                    DDS: 30
              DOB/Age: 09 Apr 1969/26Y                   Sex: FEMALE
_____________________________________________________________________________
             Sponsor Rank: CAPTAIN
              Sponsor UIC: 31127-NAVCRUSERVDET HONOLULU
                  DMIS ID: 6501-TRICARE
                      ACV: E-MCP ENROLLED/DIR. CARE CHAMPUS ELIGIBLE
          ACV Start Date: 01 Jul 1995               Region Code: 02
  Care Authorization PH#: 619-555-7526             PCM Location: CONTRACT
              Direct Care: ELIGIBLE                    Medicare: NOT ELIGIBLE
Dir Care Elig Start Date: 01 Jul 1992                  CHAMPUS: ELIGIBLE
  Dir Care Elig End Date: INDEFINITE
  Eligibility End Reason: U-Not Predictable

                                    BRAC Pharmacy Eligibility: NOT ELIGIBLE
           Override Code:

      CHAMPUS Dental Flag: 0-NO COVERAGE
        Dental Start Date:                        Dental End Date:
                  NAS Flag: YES                    Panograph Date:
     Reportable Disease                                      DNA: YES
     Database (RDDB) Date:
         Date of Request: 04 Dec 1996@1307
```

Figure 4-13. Current DEERS Eligibility Printout

4.4 Enrollees of USTF Managed Care Program

Menu Paths:

PAS System Menu → M → HMCP → PHCF

PAS System Menu → M → HMCP → AHCF

PAS System Menu → M → HMCP → NHCF

PAS System Menu → M → NMCP

PAS System Menu → M → EMCP → EENR

PAS System Menu → M → EMCP → RENR

PAS System Menu → M → IMCP → NNAS

PAS System Menu → Clerk → USV

PAS System Menu → Clerk → BOK

PAS System Menu → Clerk → AOP

- **Application Description**

Following a DEERS check, the system searches stored DEERS eligibility information to determine if the patient being processed is assigned an ACV code of "U" (Enrolled in USTF Managed Care).

The USTF Managed Care Program is a network of Department of Defense (DOD)-owned, civilian contractor-staffed medical facilities that provides DOD-funded medical care to eligible participating DOD beneficiaries (patients). The USTF Managed Care Program may be offered, where available, to eligible beneficiaries as an alternative to other DOD managed care programs, including direct care from the MTF. Active-duty patients are ineligible.

If the specified patient is not assigned an ACV code of “U,” the system allows you to continue the enrollment process without restriction. If the patient is assigned an ACV code of “U,” the system displays the DEERS Eligibility Data screen with the following message:

```
This patient is a Uniformed Services Treatment Facility (USTF) enrollee who
elected, in writing, to receive all non-emergency care from a USTF. Your facility
will not be reimbursed for care provided to this patient unless the USTF agrees
to pay your facility prior to you rendering services to the patient.
```

The system allows you to either proceed with the enrollment process or abort it for this patient. If you proceed with enrollment, DEERS will reject it.

> **Note:** Following the DEERS check the system displays the Family Member screen. Then, as a part of the DEERS interface, CHCS checks the ACV and Defense Medical Information Systems Identification (DMIS ID) fields. If the ACV field contains a value indicating enrollment in a program other than TRICARE, or if the DMIS ID field contains a code not matching one or more of the codes of the requesting CHCS host, reciprocal enrollment/disenrollment is initiated, pending user authorization.

If the DMIS ID code of the facility where the beneficiary is currently enrolled does not match any of the DMIS ID codes on the local CHCS; and if the beneficiary's ACV from

DEERS is either A, TRICARE PRIME (Active Duty); D, MEDICARE DEMONSTRATION; or E, TRICARE PRIME (CHAMPUS), the system displays the following prompt:

```
[FAMILY MEMBER NAME] IS CURRENTLY ENROLLED AT [FACILITY]. DO YOU WISH TO
DISENROLL [FAMILY MEMBER NAME] FROM [FACILITY] (EFFECTIVE ONE DAY PRIOR TO THE
ENROLLMENT DATE) AND ENROLL [NAME] AT THIS FACILITY (Y/N)?
```

You can choose whether to perform a reciprocal enrollment or disenrollment of the selected beneficiary. Refer to Section 5.3 Reciprocal Disenrollment Processing (RENR).

4.5 CHCS/DEERS Discrepancy Data Check

Menu Paths:

PAS System Menu → M → HMCP → PHCF

PAS System Menu → M → HMCP → AHCF

PAS System Menu → M → HMCP → NHCF

PAS System Menu → M → NMCP

PAS System Menu → M → EMCP → EENR

PAS System Menu → M → EMCP → RENR

PAS System Menu → M → IMCP → NNAS

PAD System Menu → ROM → FRG*

PAD System Menu → ROM → MRG*

PAD System Menu → ADT → ADM*

* New patients only.

- **Application Description**

The CHCS/DEERS Discrepancy Data Check action is automatically invoked following a normal DEERS eligibility check for all MCP patients, all non-availability statement (NAS)

requests, all first-time registered Patient Appointment and Scheduling (PAS) patients, and all admissions processing of patients. This action is also automatically invoked after an interactive DEERS eligibility check is requested.

After completing the CHCS/DEERS discrepancy data check, the system displays the results and, only when discrepancies exist, highlights the data elements where a discrepancy exists between the CHCS data on file and the DEERS data just received. The system then allows you to selectively update the CHCS file with the data shown in DEERS and/or print the discrepancy screen showing the DEERS and CHCS entries.

An entitlement discrepancy occurs when a beneficiary's eligibility changes after the beneficiary is enrolled (e.g., enrollee separates from service). You may clear an entitlement discrepancy indicator with this screen. A warning message displays if an entitlement discrepancy is present. However, if the entitlement discrepancy is not corrected, the indicator redisplays the next time an eligibility check is performed. Clearing the enrollment discrepancy does not change the MCP patient status if the patient's status is Invalid Enrollment or Invalid Disenrollment. It also does not correct the patient's ACV on DEERS. These changes can only be performed through enrollment and disenrollment options. Entitlement discrepancies may be viewed on the Enrollee Entitlement Discrepancy Report.

Refer to Figure 4-14. Enrollee Entitlement Discrepancy Report, page 4-23.

Menu Path: PAS System Menu → M → OMCP → ERME → ROST → 10

```
TRICARE SERVICE AREA (PORTSMOUTH)                                          20 Oct 1995@0804     Page 1
                                  Personal Data - Privacy Act 1974 {PL-93579)
                                   ENROLLMENT ENTITLEMENT DISCREPANCY REPORT
Division: A DIVISION
Entitlement Discrepancy: NO LONGER DIRECT CARE ELIGIBLE
=============================================================================================================
Name                      Sponsor SSN    FMP  DDS DOB      Home Ph       Street Address       City      State  Zip
  Pat Cat                 DEERS Sponsor Status
                          Original Entitlement: Direct Care   CHAMPUS       MEDICARE     ACV-Description
                          Current Entitlement:  Direct Care   CHAMPUS       MEDICARE     ACV-Description
=============================================================================================================
ABBOTT,ALLEN              800-55-0101   20    01 Jan 1955 (619) 535-1234 10260 Campus Drive   San Diego  CA 92121
  USA ACTIVE DUTY OFFICER
                          Original Entitlement: ELIGIBLE      NOT ELIGIBLE  NOT ELIGIBLE A-ACTIVE DUTY/MCP ENROLLED
                          Current Entitlement:  NOT ELIGIBLE

CAMPBELL,JANE             800-59-0210   20     02 Feb 1953 (619) 553-4321 55 Pacific Highway  San Diego  CA 92101
  USAF ACTIVE DUTY
                          Original Entitlement: ELIGIBLE      NOT ELIGIBLE  NOT ELIGIBLE A-ACTIVE DUTY/MCP ENROLLED
                          Current Entitlement:  NOT ELIGIBLE

PROVIDER,DAVID            888-08-0008   20    05 Apr 1967  (619) 287-9876 1 Main Street       San Diego  CA  92117
  USA ACTIVE DUTY ENLISTE
                          Original Entitlement: ELIGIBLE      NOT ELIGIBLE  NOT ELIGIBLE A-ACTIVE DUTY/MCP ENROLLED
                          Current Entitlement:  NOT ELIGIBLE

ROY,RANDY                 613-22-4444   20    15 May 1952  (619) 321-8765 9467 Hi Park Road   San Diego  CA 92037
  USN ACTIVE DUTY
                          Original Entitlement: ELIGIBLE      NOT ELIGIBLE  NOT ELIGIBLE A-ACTIVE DUTY/MCP ENROLLED
                          Current Entitlement:  NOT ELIGIBLE
                                                    Total for NO LONGER DIRECT CARE ELIGIBLE: 4
```

Figure 4-14. Enrollee Entitlement Discrepancy Report

```
TRICARE SERVICE AREA (PORTSMOUTH)                                                    20 Oct 1995@0804      Page 2
                                    Personal Data - Privacy Act of 1974 (PL 93-579)
                                       ENROLLMENT ENTITLEMENT DISCREPANCY REPORT
Division: A DIVISION (continued)
Entitlement Discrepancy: SPONSOR RETIRED
================================================================================================================
===
Name                    Sponsor SSN     FMP  DDS  DOB         Home Ph         Street Address       City       State  Zip
   Pat Cat              DEERS Sponsor Status
                        Original Entitlement      Direct Care  CHAMPUS            MEDICARE      ACV-Description
                        Current Entitlement       Direct Care  CHAMPUS            MEDICARE      ACV Description
================================================================================================================
===
ALLEN,THOMAS            359-55-5025      01  1   01 Jan 1945  (619) 522-7293  6745 Clairmont Mesa  San Diego   CA
92120
  A41 USA FAM MBR AD    Retired
                        Original Entitlement:    ELIGIBLE      ELIGIBLE          NOT ELIGIBLE   E-ENROLLED/DIR. CARE CHA
                        Current Entitlement:     ELIGIBLE      CHAMPUS ELIGIBLE  NOT ELIGIBLE   E-ENROLLED/DIR. CARE CHA

CARLTON,CHARLENE        098-78-5432      30  20  31 Mar 1962  (619) 734-5748  456 Mercer Avenue    San Diego   CA
92122
  F11 USAF Active Duty  Retired
                        Original Entitlement     ELIGIBLE      NOT ELIGIBLE      NOT ELIGIBLE   A-ACTIVE DUTY/MCP ENROLL
                        Current Entitlement      ELIGIBLE      CHAMPUS ELIGIBLE  NOT ELIGIBLE   A-ACTIVE DUTY/MCP ENROLL

MILLER,CHARLES L        587-66-3165      20  20  22 Jun 1942  (619) 354-9467  4853 Ruffin Road     San Diego   CA
92123
  F11 USAF Active Duty  Retired
                        Original Entitlement     ELIGIBLE      NOT ELIGIBLE      NOT ELIGIBLE   A-ACTIVEDUTY/MCP ENROLL
                        Current Entitlement      ELIGIBLE      CHAMPUS ELIGIBLE  NOT ELIGIBLE   E-MCP ENROLLED/DIR.CARE
CHA

                                                                                    Total for SPONSOR RETIRED:
3
                                                                                         Total for A DIVISION:
7
                                                                                   Total for Selected Division(s):
7
```

Figure 4-14. Enrollee Entitlement Discrepancy Report (continued)

CHCS DEERS Discrepancy Data screen

The system automatically initiates the CHCS/DEERS discrepant data check following the interactive DEERS eligibility check within MCP options for first-time registered patients and all patients being processed for admissions. Anytime data fields are discrepant after an eligibility response is received from DEERS, the system displays the CHCS/DEERS Discrepancy Data screen.

The system displays patient data found in CHCS and in DEERS and highlights the elements that have a discrepancy. The system then displays an action bar allowing you to update CHCS data from DEERS, print discrepancies, clear entitlement discrepancies, continue, or quit processing. Refer to Figure 4-15. Initial CHCS/DEERS Discrepancy Data Screen, page 4-26.

```
                          CHCS/DEERS DISCREPANCY DATA
              Name: MOREHOUSE,KATHERINE                FMP/SSN: 30/577-23-3789
  Patient Category: USA FAM MBR AD                         DDS: 30
        MCP Status: PENDING ENROLLMENT                 DOB/Age: 09 Apr
1969/26Y
               ACV: E-TRICARE PRIME (CHAMPUS)          DMIS ID: 6501
       Direct Care: ELIGIBLE                         Medicare: NOT ELIGIBLE
--------------------------------------------------------------------------------
--
                     CHCS Data                          DEERS Data
_______________________________________________________________________________
__

   Name           : MOREHOUSE,KATHERINE
   DOB            : 09 Apr 1969                       10 Apr 1969
   Sex            : FEMALE                            FEMALE
   Patient SSN    : 577-23-3789                       577-23-3789

   Sponsor Rank   : CAPTAIN                           CAPTAIN
   PatCat/Status  : ACTIVE DUTY                       ACTIVE DUTY
   Station/Unit   : 1912 COMMUNICATIONS               0001 MEDICAL
_______________________________________________________________________________
_

Select (U)pdate CHCS, (P)rint Discrepancies, (C)ontinue, or (Q)uit: C//
```

Figure 4-15. Initial CHCS/DEERS Discrepancy Data Screen

The CHCS/DEERS discrepancy data action bar includes the following actions:

– (U)pdate CHCS - Allows you to select the data elements to be updated and steps through the update process for each element selected.

– (P)rint Discrepancies - Prompts for the output device, prints the discrepancy listing, and returns to the action bar. Refer to Figure 4-16. CHCS/DEERS Discrepancy Data Continued, page 4-27.

```
                        CHCS/DEERS DISCREPANCY DATA
              Name: MOREHOUSE,KATHRYN              FMP/SSN: 30/577-23-3789
   Patient Category: USA FAM MBR AD                    DDS: 30
         MCP Status: ENROLLED                       DOB/Age: 09 Apr 1969/26Y
                ACV: E-TRICARE PRIME (CHAMPUS)      DMIS ID: 6501
        Direct Care: ELIGIBLE                       Medicare: NOT ELIGIBLE
-------------------------------------------------------------------------------

This action will clear the Entitlement Discrepancy for this patient. Depending
upon the exact nature of the Entitlement Discrepancy, it may re-appear the next
time an eligibility check is performed. In such a case, it will be necessary
to disenroll and then re-enroll the patient. Also, clearing the enrollment
discrepancy will not change the MCP Patient Status if the patient's status is
INVALID ENROLLMENT or INVALID DISENROLLMENT nor will it change the patient's
ACV on DEERS. These changes can only be done through the enrollment and
disenrollment options.
 ______________________________________________________________________________
 Are you sure you wish to proceed? No//YES
```

Figure 4-16. CHCS/DEERS Discrepancy Data Continued

(C)ontinue - Proceeds to the next step in the option being processed (normally the Demographics Display screen).

Note: Beginning with CHCS Version 4.6, you can continue the enrollment process without correcting data discrepancies. Prior to CHCS Version 4.6, users were required to make the corrections or abort the enrollment process.

– (Q)uit - Exits the option in process.

- **Data Entry Process**

Correct CHCS/DEERS data discrepancies

Clear entitlement discrepancy

Select CHCS data to correct

Confirm correction of CHCS data to match DEERS

Correct UIC in CHCS

Clear entitlement discrepancy

If the patient category is inconsistent with the ACV, the beneficiary may need to be disenrolled or the patient category could be incorrect. Make the appropriate corrections.

Select CHCS data to correct

After you select the CHCS data to correct, the system asks you to confirm that you want to update CHCS data with DEERS data. If you enter “Y” for yes, CHCS automatically replaces the CHCS data with the DEERS data.

Refer to Figure 4-17. CHCS/DEERS Discrepancy Data (DOB and Station/Unit Selected), page 4-29.

```
                        CHCS/DEERS DISCREPANCY DATA
             Name: MOREHOUSE,KATHERINE                FMP/SSN: 30/577-23-3789
  Patient Category: USA FAM MBR AD                        DDS: 30
       MCP Status: PENDING ENROLLMENT                  DOB/Age: 09 Apr
1969/26Y
              ACV: E-TRICARE PRIME (CHAMPUS)           DMIS ID: 6501
      Direct Care: ELIGIBLE                          Medicare: NOT ELIGIBLE
--------------------------------------------------------------------------------
--
                    CHCS Data                          DEERS Data
________________________________________________________________________________
__

   Name           : MOREHOUSE,KATHERINE
 * DOB            : 09 Apr 1969                       10 Apr 1969
   Sex            : FEMALE                            FEMALE
   Patient SSN    : 577-23-3789                       577-23-3789

   Sponsor Rank   : CAPTAIN                           CAPTAIN
   PatCat/Status  : ACTIVE DUTY                       ACTIVE DUTY
 * Station/Unit   : 1912 COMMUNICATIONS               0001 MEDICAL
________________________________________________________________________________
_

Select (U)pdate CHCS, (P)rint Discrepancies, (C)ontinue, or (Q)uit: C//
```

Figure 4-17. CHCS/DEERS Discrepancy Data (DOB and Station/Unit Selected)

Press <Select> by each data element to be updated.

Confirm correction of CHCS data to match DEERS

Refer to Figure 4-18. CHCS/DEERS Discrepancy Data (shows discrepancies in Station Unit data), page 4-29.

```
                        CHCS/DEERS DISCREPANCY DATA
               Name: MOREHOUSE,KATHRYN              FMP/SSN: 30/577-23-3789
   Patient Category: USA FAM MBR AD                     DDS: 30
         MCP Status: ENROLLED                        DOB/Age: 09 Apr 1969/26Y
                ACV: E-MCP ENROLLED/DIR.CAR CHAM     DMIS ID: 6501
        Direct Care: ELIGIBLE                       Medicare: NOT ELIGIBLE
-------------------------------------------------------------------------
                      CHCS DATA                     DEERS DATA
 _____________________________________________________________________________
    DOB             : 09 Apr 1969                  10 Apr 1969
    Station/Unit    : 1912 COMMUNICATIONS          0001 MEDICAL           GP
    UIC Code        : 21810                        LE1CF602


_____________ CAUTION: Data selected will be changed in CHCS files ________
 Are you sure you want to update the CHCS data with the DEERS data? NO// Y
```

Figure 4-18. CHCS/DEERS Discrepancy Data (shows discrepancies in Station Unit data)

Enter "Y" to overlay the CHCS data with the DEERS data.

Correct UIC in CHCS

Refer to Figure 4-19. CHCS/DEERS Discrepancy Data, page 4-30.

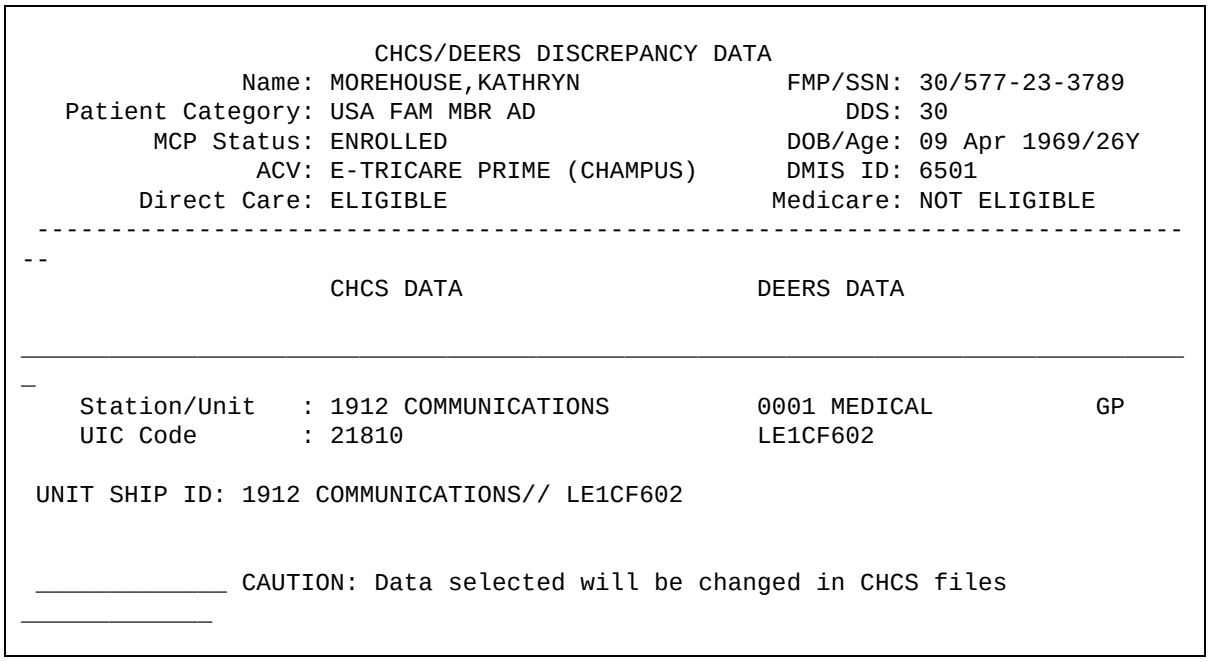

Figure 4-19. CHCS/DEERS Discrepancy Data

1. UIC Code

   Enter sponsor's correct UIC and press <Return>.

4.6 Interactive DEERS Eligibility Request

Menu Paths:

PAS System Menu → M → EMCP → IENR

PAS System Menu → M → RMCP → RREG → DRDM

PAS System Menu → M → IMCP → NNAS*

PAS System Menu → Clerk → ROM → DRDM

PAS System Menu → EMER → RER → 2

PAD System Menu → ROM → DER

* The NNAS option does not allow you to enter a specific date range.

- **Application Description**

The Interactive DEERS Eligibility Request option enables you to directly query DEERS to perform a DEERS eligibility check on a selected patient. To uniquely identify the patient, you must enter the patient name, DOB, sponsor SSN, and FMP. The system allows you to specify eligibility start and end dates to determine whether a patient who is currently ineligible in DEERS is eligible at an earlier or later date. The patient is not required to be registered in CHCS to perform this check.

This option, unlike other options that perform DEERS checks, always queries DEERS directly. It does not use DEERS data stored in the CHCS Patient file by DEERS checks performed by other options within the past five days. It does not store the DEERS data from this check in the Patient file for the benefit of other options that check DEERS eligibility.

- **Required Fields**

Patient name
FMP/SSN
DOB
Eligibility start date
Eligibility end date
Output device

- **Data Entry Process**

Perform a DEERS eligibility check on a selected patient

Access the IENR option

Select the patient name

Complete the DEERS Interactive Request screen

Print DEERS Eligibility data

Access the IENR option

Select the patient name

The system prompts you to enter and confirm the name of a patient. Refer to Figure 4-20. DEERS Post Eligibility Request, page 4-32. If the patient is not registered in CHCS, the system asks you whether to continue with the DEERS search or to quit the option.

```
MCP-DEERS Post Eligibility Request

Select PATIENT NAME: MITCHELL,ANDREA   30/567-56-5678 09 Aug 1961 F
          OK? YES
```

Figure 4-20. DEERS Post Eligibility Request

Complete the DEERS Interactive Request screen

If the patient is registered or you continue even though the patient is not registered, the system displays the DEERS Interactive Request screen, and prompts you to enter data essential for a DEERS query. Refer to Figure 4-21. DEERS Interactive Request Screen, page 4-32. If the patient is registered, the default values for patient name, DOB, and FMP/SSN are taken from CHCS.

```
                  Patient Name: MITCHELL,ANDREA
                  Date of Birth: 09 Aug 1961
                    Sponsor SSN: 567565678
            Family Member Prefix: 30
          Eligibility Start Date: 25 Jul 1994
            Eligibility End Date: 01 Jan 2001

      When requesting information for a sponsor, enter 99 for the
        family member prefix to return all of the family members.


_____________________________________________________________________________
File/exit    Abort    Edit File changes and exit.
```

Figure 4-21. DEERS Interactive Request Screen

1. Patient Name

   Press <Return> to accept the patient name you just entered at the *Select PATIENT NAME* prompt.

2. Date of Birth

   Press <Return> to accept the DOB from CHCS data previously entered. Enter the DOB if the patient is not registered.

3. Sponsor SSN

   Press <Return> to accept the sponsor SSN from CHCS data previously entered. Enter the sponsor SSN if the patient is not registered.

4. Family Member Prefix

   Press <Return> to accept the FMP from CHCS data previously entered. Enter the FMP or 99 if the patient is not registered.

> **Note:** When requesting information for a sponsor, you can enter 99 in the family member prefix field to see a list of all the family members.

5. Eligibility Start Date and Eligibility End Dates

   Enter desired dates of eligibility.

6. If the system fails to find a record with the specified sponsor SSN and DOB, the system displays the search criteria data you entered on the DEERS Eligibility Data screen, and permits you to print that data.

7. If the system finds records with the specified sponsor SSN but not the specified DOB, the system displays a picklist from DEERS of all family members with the same sponsor SSN, and prompts you to select the desired family member. After you select the family member, the system displays the DEERS data for that family member on the DEERS Eligibility Data screen, and permits you to print the eligibility data. If the DOB on that family member does not match DEERS, you are prompted to accept the DEERS DOB. If you answer "Yes," CHCS is updated with the DEERS DOB.

8. The system then exits the option.

Print DEERS Eligibility data

As soon as you file data on the DEERS Interactive Request screen, the system requests a DEERS search. If a record is found with the specified sponsor SSN and DOB, then CHCS displays the DEERS data on the DEERS Eligibility Data screen, and permits you to print the eligibility data.

Refer to Figure 4-8. DEERS Eligibility Data, page 4-12, for a sample.

> **Note:** Following the DEERS check, the system searches the DEERS eligibility information to determine if the patient is assigned an ACV code of "U" (Enrolled in USTF Managed Care). Refer to Section 4.4 Enrollees of USTF Managed Care Program, page 4-19, for an explanation of this processing.

- **Functionality Interactions**

  None

4.7 DEERS Purge Parameter

Menu Path: Systems Manager Menu (EVE) → SM → INT → DEERS → EDP

- **Required Fields**

  DEERS Purge List File Name

- **Application Description**

The MCP DEERS enrollment responses purge parameter tells CHCS how long to store the DEERS discrepancy code in the DEERS MCP Enrollment Responses file. The system default is set for two days. This should be changed to at least five days. The enrollment response is now stored in the MCP Patient file.

The DEERS discrepancy code flags an MCP Patient with an MCP status of Invalid Enrollment or Invalid Disenrollment to appear on the Enrollment/Disenrollment Discrepancy Report. The reason code and reason code description printed on this report helps you to resolve the discrepancy. Once the DEERS Discrepancy code flag is purged from the system, the patient flagged longer appears on the Enrollment/Disenrollment Discrepancy Report, and the patient's invalid status is not reported to the user.

- **Data Entry Process**

Change the DEERS purge parameter

Access the EDP option
Enter the file name
Enter the purge parameter

Access the EDP option

Enter the file name

At the *Select DEERS PURGE LIST FILE NAME* prompt, enter
DEERS MCP ENROLLMENT RESPONSES

Enter the purge parameter

At the *Enter the number of days a DEERS response can remain in this file* prompt, enter the number of days to save the responses. The default for the number of days is set initially to 2.

Exit the option

- **Functionality Interaction**

Once the DEERS Discrepancy code flag is purged from the system, the patient flagged longer appears on the Enrollment/Disenrollment Discrepancy Report, and the patient's invalid status is not reported to the user.

- **Troubleshooting**

None

4.8 PAS DEERS Ineligibility Report

Menu Paths:

PAS System Menu → SCH → ORDM → 4

PAS System Menu → M → OMCP → DEMR → 4

PAS System Menu → M → EMCP → OENR → DRPM → 4

- **Contents**

The PAS DEERS Ineligibility Report option allows you to generate a report listing those patients who have had a DEERS check performed by the PAS Subsystem, and who have been returned as DEERS ineligible.

The report is generated in association with the nightly process (batch job) SD DINQ, which automatically sends DEERS eligibility requests for those patients with scheduled appointments on a future date equal to today plus the number of days specified in the DEERS Batch Pull field in the facility profile.

Based on the results of the eligibility requests, the PAS DEERS Ineligibility Report lists those patients with appointments scheduled who either are ineligible for direct care or were not included in responses from DEERS eligibility requests.

The system generates Page 2 of this report only when DOD-sponsored patients have been designated direct care and are CHAMPUS ineligible because they have elected to obtain medical treatment through a USTF.

> **Note:** The USTF Managed Care Program is a network of DOD-owned, civilian contractor-staffed medical facilities that provides DOD-funded medical care to eligible participating DOD beneficiaries (patients). The USTF Managed Care Program may be offered, where available, to eligible beneficiaries as an alternative to MTF direct-care and other DOD managed care programs. (Active-duty patients are ineligible.) A USTF enrollee is direct-care ineligible and CHAMPUS ineligible.

The report may be requested by clinic, division, or group. The report is sorted by patient identification (PTID) and shows the patient demographics data (patient's name, FMP/SSN, date of birth), current DEERS status, date of the last DEERS check, next appointment, home phone and work phone.

1. The system prompts you to print the report for a selected clinic, division, or group.
2. Following this selection, the system displays a warning that this is a 132-column report and will be available tomorrow morning. You may either proceed or exit the option.
3. If you proceed, the system prompts for the desired output device, queues the requested report for processing and printing, then exits the option.

- **Use/Frequency**

Run this report, as needed, to see a list of patients who have applied for care that are not eligible.

- **Report Sample**

Refer to Figure 4-22. PAS DEERS Ineligibility Report, page 4-38.

```
TRAINING MEDICAL TREATMENT FACILITY                                                    21 Jun 2001@1615    Page 1
                                          PAS DEERS INELIGIBILITY REPORT by CLINIC
                                       Personal Data - Privacy Act of 1974 (PL 93-579)
                                                Appointments for  22 Jun 2001
                                                        Part 1 of 2
Clinic: CARDIOLOGY CLINIC
================================================================================================================
==
  Patient Name          FMP/SSN         DOB          Last DEERS Check  Next Appt.       Home Phone/      Work Phone
  DEERS Status                                                                                          Clerk
================================================================================================================
==
  SUMMERS,ALLAN A       20/600-60-6510  20 Oct 1975  18 Jun 2001       22 Jun 2001@1300  918-555-6712    202-555-
3067
  No response on latest DEERS check. Previous check: ELIGIBLE
TRAINING,MANAGER

  SUMMERS,ALLAN A       20/600-60-6510  20 Oct 1975  18 Jun 2001       22 Jun 2001@1400  918-555-6712    202-555-
3067
  No response on latest DEERS check. Previous check: ELIGIBLE
TRAINING,MANAGER









================================================================================================================
==
NOTE: Patients, whose names appear on this report, should be reminded to bring proof of their eligibility at the
time of their appointment.
```

Figure 4-22. PAS DEERS Ineligibility Report

```
TRAINING MEDICAL TREATMENT FACILITY                                                    21 Jun 2001@1459    Page 2
                                        PAS DEERS INELIGIBILITY REPORT by CLINIC
                                     Personal Data - Privacy Act of 1974 (PL 93-579)
                                             Appointments for 22 Jun 2001
                                                     Part 2 of 2
Clinic: CARDIOLOGY CLINIC
================================================================================================================
==
  Patient Name          FMP/SSN         DOB          Last DEERS Check  Next Appt.        Home Phone/       Work
Phone
  Alternate Care Value                  DEERS Direct Care Eligibility                    Clerk
================================================================================================================
==
  SUMMERS,ALLAN A       20/600-60-6510  20 Oct 1975  18 Jun 2001       22 Jun 2001@1300  918-555-6712    202-555-
3067
  U/ENROLLED in USF MANAGED CARE        ELIGIBLE                                         TRAINING,MANAGER

  SUMMERS,ALLAN A       20/600-60-6510  20 Oct 1975  18 Jun 2001       22 Jun 2001@1400  918-555-6712    202-555-
3067
  U/ENROLLED in USF MANAGED CARE        ELIGIBLE                                         TRAINING,MANAGER









================================================================================================================
==
NOTE: Patients, whose names appear on this report section are currently in a Uniformed Services Treatment
Facilities (USTF) Managed Care Plan. This facility will not be reimbursed for non-emergency care provided to these
patients unless their USTF agrees to pay this facility prior to rendering services to the patient.
```

Figure 4-22. PAS DEERS Ineligibility Report (continued)

4.9 MCP DEERS Ineligibility Report

Menu Paths:

PAS System Menu → M → OMCP → DEMR → 3

PAS System Menu → M → EMCP → OENR → DRPM → 3

- **Contents**

The MCP DEERS Ineligibility Report option allows you to generate a report, within a specified date range, showing all patients who have had a DEERS check performed by a MCP option and who were found to be ineligible. For each patient, the report lists patient demographics, date of last DEERS check, and pending appointments.

- **Use/Frequency**

Run this report, as needed, to see a list of patients who have applied for care that are not eligible.

- **Report Sample**

Refer to Figure 4-23. MCP DEERS Ineligibility Report, page 4-42.

```
TRAINING MEDICAL TREATMENT FACILITY                                                    21 Jun 2001@1618     Page
1
                                        Personal Data - Privacy Act of 1974 (PL 93-579)
                                                MCP DEERS INELIGIBILITY REPORT
                                              From: 20 Jun 2001    To: 21 Jun 2001
================================================================================================================
==
Patient            FMP/SSN         Sex DOB          Date of Trans    Home Phone        Work Phone      Pending
Appts
   Sponsor                          Sponsor Unit                     Duty Phone      Override   MCP Status  Process
Type
================================================================================================================
==
INGRAM,JACKIE J    20/711907401    F   19 Apr 1966  10 Jan 2000      H:918-555-7864    W:918-555-9081  Appts:
  INGRAM,JACKIE J                   0121 FIGHTER SQ                  D:918-555-9081
INTERACTIVE

NAPOLI,FLORENCE    20/100107144    F   06 May 1971  18 Jun 2001      H:619-555-9838    W:              Appts:
  NAPOLI,FLORENCE                 USS JOHN F KENNEDY CV 67          D:
INTERACTIVE

NAPOLI,HOLLEY      20/100107146    F   12 Aug 1971  18 Jun 2001      H:619-555-9878    W:              Appts:
  NAPOLI,HOLLEY                   USS JOHN F KENNEDY CV 67          D:
INTERACTIVE

NAPOLI,JACKIE      20/100107148    F   21 Jun 1971  18 Jun 2001      H:619-555-7893    W:              Appts:
  NAPOLI,JACKIE                   USS JOHN F KENNEDY CV 67          D:
INTERACTIVE

NAPOLI,LINDA       20/100107149    F   27 Jun 1971  18 Jun 2001      H:619-555-8383    W:              Appts:
  NAPOLI,LINDA                    USS JOHN F KENNEDY CV 67          D:
INTERACTIVE

NATWICK,ALLAN      20/100107150    M   08 Jul 1971  18 Jun 2001      H:619-555-8896    W:              Appts:
  NATWICK,ALLAN                   USS JOHN F KENNEDY CV 67          D:
INTERACTIVE

NATWICK,BARBARA    20/100107151    F   21 May 1971  18 Jun 2001      H:619-555-8382    W:              Appts:
  NATWICK,BARBARA                 USS JOHN F KENNEDY CV 67          D:
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INTERACTIVE

NATWICK,CHARLES    20/100107152    M   09 Aug 1971  18 Jun 2001      H:619-555-8381    W:              Appts:
  NATWICK,CHARLES                 USS JOHN F KENNEDY CV 67          D:
INTERACTIVE

NATWICK,DONNA      20/100107153    F   25 Feb 1971  18 Jun 2001      H:619-555-8385    W:              Appts:
  NATWICK,DONNA                   USS JOHN F KENNEDY CV 67          D:
INTERACTIVE
```

Figure 4-23. MCP DEERS Ineligibility Report

Section 5 Enrollment Processing

5. ENROLLMENT PROCESSING

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Introduction

Each site can use either Local Empanelment or DEERS Enrollment modes. An entry in the Enrollment Mode field on the MCP Parameters Profile screen determines whether the site uses the Local Empanelment or DEERS Enrollment mode. This field controls processing for non-active-duty beneficiaries only; active-duty and Medicare beneficiaries are not affected. All sites in a region should be set to the same mode consistent with the conditions of the TRICARE contract.

Local Empanelment Mode - This mode allows a site to conduct managed care activities on a local level without changing the non-active-duty beneficiaries' Alternate Care Value (ACV) on the Defense Enrollment Eligibility System (DEERS) database. Local empanelment, non-active-duty beneficiaries receive the standard Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) benefits, the enhancement of a primary care manager (PCM) and other managed care activities. The Managed Care Program (MCP) enrollment beneficiary information is not sent to DEERS, although standard CHAMPUS eligibility information is available from DEERS.

While in the Local Empanelment mode, DEERS enrollment information does not match information in CHCS. CHCS shows the beneficiary as enrolled, but in DEERS the beneficiary may not be enrolled if the beneficiary was or was not enrolled by the TRICARE contractor system.

> **Note:** While in Local Empanelment mode, enrollment and disenrollment transactions are still sent to DEERS for active-duty and Medicare (TRICARE Senior) beneficiaries. Active-duty and Medicare enrollments are not affected by this mode switch.

DEERS Enrollment Mode - This mode allows a site to formally conduct managed care activities; enrollment and disenrollment transactions are sent to DEERS for all beneficiaries, changing the beneficiaries' ACVs. The Fiscal Intermediary (FI) can view the ACV, and thereby the enrollment status, for a given beneficiary when processing TRICARE claims. Full enrollment supports the TRICARE benefit.

If the beneficiary is enrolled in TRICARE by another system, on another CHCS platform, or in another program, check the DEERS Eligibility screen for this enrollment information. The ACV will be other than "A", "D", or "E." You will need to know region by region, who is enrolling specific categories of beneficiaries to determine who enrolled the patient.

All sites and divisions sharing a CHCS platform must use the same enrollment mode, which is set in the MCP Parameters Profile. Active-duty and beneficiaries are always processed in Enrollment Mode regardless of the enrollment setting. For non-active-duty beneficiaries local enrollments, all transactions for all sites are sent to DEERS if the enrollment mode is set to “enrollment”, and they are not if the enrollment mode is set to “empanelment”.

Refer to PAS: MCP File Maintenance Functions, SAIC/CHCS Doc. TC-4.5-0565, for more information.

5.1 Enrollment Enter/Edit (EENR)

Menu Path: PAS System Menu → M → EMCP → EENR

- **Security Keys**

  CPZ CCP

> **Note:** Be aware that the Track User Report indicates the users who are creating and updating enrollments. Take proper security measures such as halting your CHCS session prior to leaving your terminal so no one else can enter data attributed to you.

- **Required Fields**

  Patient Name
  Sponsor Name
  PCM Name
  OHI Name
  Policy Holder Name

- **Application Description**

The Enrollment Enter/Edit option allows you to enroll a patient in MCP and assign a PCM. Once you enter the patient name and register the patient, you can enter, view, and edit the current MCP enrollment for the patient. To complete an enrollment, you must assign a PCM or the enrollment is deleted.

Just as you can register patients in the facility when you book appointments for them or check them in for an appointment, you can also register patients as you enroll them in MCP. The functionality to register patients is embedded in the enrollment option; that is, you do not need to change menu options to complete a patient’s registration.

Reciprocal Enrollments/Disenrollments - You may enroll a beneficiary at your site who is currently enrolled at another CHCS site without exiting this option. You can perform a "Reciprocal Enroll/Disenrollment" – that is, you may disenroll the beneficiary from the losing facility one day prior to your facility enrollment start date, and enroll the beneficiary at your site. In order to do this, the following conditions must be present: You enter a beneficiary's name; the DEERS eligibility check shows that the DMIS ID Code of the facility where the beneficiary is currently enrolled does not match any local DMIS ID codes in CHCS and the ACV from DEERS is Active Duty Enrolled (“A”), Enrolled/Not CHAMPUS Eligible (“D”), or CHAMPUS Eligible/Medicare Ineligible (“E”).

> **Note:** If a beneficiary does not wish to be enrolled, but must disenroll from a prior facility. Refer to Section 5.3 **Disenrollment (DENR)**, for further information on Reciprocal Disenrollments.

Renew Enrollments - This option allows you to renew enrollments for non-active-duty beneficiaries prior to expiration of the current term of enrollment (same DMIS ID). The Renew Enrollment action is located on the Demographics Display action bar. The Renew action only displays for those beneficiaries who are currently enrolled and that have not had their current enrollment episode renewed or have not been disenrolled. Those beneficiaries with a status of Conditionally Enrolled, Pending Enrollment, Invalid Enrollment or Ineligible will not have the Renew Enrollment action displayed. Renewals can also be batch entered in another menu option.

When you elect to exercise the Renew action, the system extends the enrollment end date one year from the current end date, and allows you to enter a free text comment regarding the renew action. No other field can be edited other than the comment field. Upon completion of this process the system returns to the Demographics Display action bar. Once a beneficiary's enrollment episode has been renewed for the coming year, the Renew action is no longer displayed. Only when today's date falls within the renewed enrollment episode will the Renew Enrollment action again be displayed.

Other Options - You can print PCM place of care and assignment preferences. Additionally, you can add/edit/view or copy other health insurance (OHI) information, or print an enrollment form and/or patient address label.

You can also disenroll an enrolled patient and reenroll a disenrolled patient, so a patient may have more than one enrollment record. You can display/print any enrollment record in the patient's enrollment history. The system also tracks family relationships of enrolled

patients and permits you to enroll other eligible family members. You can copy the same PCM to several family members.

After completion of an enrollment or disenrollment, the system sends an enrollment transaction or disenrollment transaction to DEERS as a background process for non-active-duty patients (if in enrollment mode) and always for active-duty.

The MCP status (Enrolled, Disenrolled, Invalid...) is updated at night when the CP Enrollment Bulletin runs.

> **Note:** The CP Enrollment Bulletin must run in order to validate the patient's current status and the success of the enrollment. The Bulletin is responsible for setting the invalid enrollments to an invalid status. Otherwise, the enrollments will appear valid in error. The CP Enrollment Bulletin is scheduled by the system to run automatically.

- **Business Rules**

– DEERS stores the ACV, DMIS ID, Region Code, PCM Phone, PCM Location, date of the last DEERS check, patient eligibility, patient's eligibility start and stop dates, and Medicare and CHAMPUS eligibility. This information is downloaded to CHCS in the Patient file for the patient enrolled in TRICARE Prime or another benefit.

– The PCM name does not display for remotely enrolled patients.

– A beneficiary, Medicare eligible and also CHAMPUS eligible, regardless of age, continues to be grouped under the appropriate Beneficiary Category and is NOT be grouped under the Medicare Category.

– A Medicare-eligible beneficiary, 65 years of age or older, and not CHAMPUS-eligible, is categorized under the new Medicare Beneficiary category.

– The system categorizes patients who are Medicare eligible according to their DEERS Medicare Status.

– A Medicare-eligible and CHAMPUS-eligible beneficiary, regardless of age, is assigned an ACV of "E."

– A Medicare-eligible beneficiary 65 years of age or older, and not CHAMPUS-eligible, is assigned an ACV of "D."

– Updated PCM capacity restrictions are not be retroactive for currently assigned beneficiaries; therefore, no automatic reassignment will take place. Users who are responsible for Provider Network maintenance must evaluate the numbers and, as policy dictates, make reassignments manually.

- The system does not allow Direct Care Only enrollees, including Medicare beneficiaries under the age of 65 to enroll.

- Beneficiaries are assigned to PCMs based on the specific MCP Agreement Type(s) held by each PCM. A beneficiary who is grouped under the Medicare Beneficiary Category may be assigned only to PCMs who have entered into the following MCP Agreement Types with the facility:

  MTF - MTF STAFF
  CON - CONTRACT

5.1.1 Enroll a Patient

Menu Path: PAS System Menu → M → EMCP → EENR

Enroll a Patient

- **Data Entry Process**

Access the Enrollment Enter/Edit (EENR) option on the Enrollment Processing Menu

Identify patient

Patient already registered

Register patient if not registered

Enter sponsor name

Complete patient initial information

DEERS processing

DEERS check (Enrollment/Family Member screens)

Confirm the patient for enrollment

Select patients for enrollment processing

Access the Enrollment Enter/Edit (EENR) option on the Enrollment Processing Menu

Identify patient

Enter the patient identifier and the sponsor identifier.

The patient identifier is usually the same name.

Patient already registered

If the patient, whose name has just been entered, is already registered at this facility, a current DEERS eligibility screen displays.

The Demographics Display screen displays. Refer to Figure 5-1. Demographics Display Screen, page 5-9. The patient's registration data can then be edited, if necessary, before continuing with the enrollment process.

```
                              DEMOGRAPHICS DISPLAY

                  Name: PEARL,ZACHARY N.      FMP/SSN: 20/569-69-4415
      Patient Category: USN ACTIVE-DUTY           DDS:
          Patient Type:                           Sex: MALE
            MCP Status:                       DOB/Age: 12 Jun 1975/26Y
                   ACV:                       DMIS ID:
           Direct Care:                      Medicare:

          Sponsor Name: PEARL,ZACHARY N.         Rank: CHIEF PETTY OFFICER
          Station/Unit: W. R. MED HOLD PP         DSN: 331
          Home Address: 1020 NEWPORT DRIVE
                  City: HAMPTON                State: VIRGINIA
              ZIP Code: 23665              Home Phone: 974-2333
            Duty Phone: 804-555-4993       Work Phone: 804-555-4993
  Registration Comment: new patient
Last Registration Date: 21 Jun 2001@152316
Outpatient Record Room: MEDICAL RECORDS FILE ROOM
       MCP Enroll Date:               End Enroll Date:
  Primary Care Manager:                     PCM Phone:
           Primary OHI: NOT ASSIGNED        Case Mgmt:

Select (F)ull, (M)ini, (E)nrollment, (N)ew Patient, or (Q)uit DEMOGRAPHICS: Q//
```

Figure 5-1. Demographics Display Screen

Register patient if not registered

If the patient is not registered at this facility, the system allows you to register the patient using Mini Registration. The only data that CHCS can update in DEERS is the address, phone number, and organ donor response.

Enter sponsor name

If the patient is the sponsor, you must still enter the patient's name as the sponsor name. If the beneficiary is new to the facility, you must register the sponsor first, even if the sponsor does not live in the local area. Sponsors do not have to be enrolled for you to enroll a family member. In this example, the patient is the sponsor.

Instead of retyping the patient name at this prompt, you can press the spacebar, then <Return>. This causes the system to reenter the patient name you most recently processed in CHCS MCP.

Complete patient initial information

The Patient - Initial Information screen displays. Refer to Figure 5-2. Patient - Initial Information Screen, page 5-10. If the patient is not currently registered in CHCS, an Initial Information screen displays.

```
                        Patient - Initial Information

                Patient Name: PEARL,ZACHARY N
                         FMP: 20
                         DOB: 12 Jun 1975
                         SSN: 569-69-4415
                      PATCAT: N11









Help = HELP      Exit = F10     File/Exit = DO                          INSERT OFF
```

Figure 5-2. Patient - Initial Information Screen

1. FMP

   The family member prefix (FMP) for the sponsor is 20. The FMP is used to signify the relationship between the sponsor and the patient. If the sponsor and the patient are the same, the cursor displays in the Sponsor FMP field, and you must enter 20 as the sponsor FMP.

   If the sponsor is not the same as the patient, the FMP field is blank. You must enter the patient's FMP.

2. DOB

   Enter the patient date of birth (DOB). Check the DEERS Eligibility Data screen for the DOB to ensure the correct date. If the correct DOB is not available, you may choose not to enroll the patient until the correct DOB is known. DEERS does not enroll the patient if the CHCS DOB does not match the DEERS DOB. Usually these patients are not enrolled until they correct their DOB in DEERS. If the exact DOB is unknown (Example: A John Doe patient), enter an estimated year of birth.

3. SSN

   Enter the nine-digit Social Security number (SSN) for this patient in the format nnn-nn-nnnn. (You need not enter the dashes.) If the SSN is unknown (Example: A John Doe patient), enter P and the system generates a pseudo SSN and enters it in this field.

4. Verify SSN

   As soon as the SSN entry is completed, the system deletes the SSN from view and asks you to verify the patient's SSN entry.

   Entering the patient's SSN twice is a system device to ensure the accuracy of the SSN.

   The two SSN entries must match before the system allows you to continue with the registration.

   If the two SSN entries do not match, you must reenter the SSN.

5. Enter the PATCAT.

   The patient category (PATCAT) indicates the patient's service affiliation and entitlement.

   If the patient category is unknown, enter a double question mark (??) to display a list of valid patient category codes. Only patient categories ending in 11 (active-duty), 31 (retired), 41 (active-duty family member), or 43 (retiree family member) are valid for enrollment. CHCS calculates the ACV (based on PATCAT, age, eligibility data), which is verified by DEERS. DEERS rejects the enrollment if the ACV is inconsistent with the patient's beneficiary category on DEERS so it is important to correct the patient category in CHCS if inconsistent with the DEERS patient status.

6. File the data.

DEERS processing

After the initial information screens have been filed, a DEERS eligibility check is automatically processed through the CHCS/DEERs interface. DEERS determines eligibility for health care. Enrollment begins with a request for family member eligibility from DEERS.

The system requests a family list from the DEERS database, then displays the Family Member screen from the DEERS data. The Family Member screen is requested using the sponsor SSN; therefore, correct sponsor identification is required. Refer to Figure 5-3. Family Member Screen, page 5-14.

DEERS check (Enrollment/Family Member screens)

The DEERS check (Enrollment/Family Member screens) action is invoked for patients being processed through the Enrollment Enter/Edit option or the Reciprocal Disenrollment Processing option only.

The DEERS check downloads patient eligibility and enrollment data directly from the DEERS database and displays the data on the DEERS Eligibility screens. The eligibility response contains data that can be used to correct CHCS data prior to the enrollment process. The system currently displays discrepant demographic data between CHCS and DEERS. If some of these demographic data elements are discrepant (e.g., sponsor status), DEERS may not accept the enrollment. This would result in an avoidable enrollment processing discrepancy.

The DEERS check is invoked to determine a selected patient's eligibility for Direct Care, CHAMPUS, and Medicare in addition to informing you of enrollment status and participation in other programs, such as CHAMPUS Dental. The Family Member screen may display up to 23 members per family.

During enrollment processing, it is likely that other family members will be enrolled along with the initially selected patient. The family screen method of processing the DEERS check allows you to rapidly process all selected family members through DEERS and determine the eligibility for each. The family member connection is established by the sponsor SSN.

If a selected patient is determined to be ineligible as a result of the DEERS check, and you have sufficient information to continue an enrollment, the system only allows you to enter an override reason and continue processing the enrollment for a newborn. CHCS sets up a conditional enrollment with DEERS until eligibility can be confirmed. However, DEERS does not accept enrollment on an ineligible patient except in the case of a newborn.

Enrollees of Uniformed Services Treatment Facility (USTF) Managed Care Program - Following the DEERS check, the system searches DEERS eligibility information stored locally in CHCS to determine whether the patient is assigned an ACV code of "U" (Enrolled in USTF Managed Care).

> **Note:** The USTF Managed Care Program is a network of DOD-owned, civilian contractor-staffed medical facilities that provides DOD-funded medical care to eligible participating DOD beneficiaries (patients). The USTF Managed Care Program may be offered, where available, to eligible beneficiaries (active-duty patients are ineligible) as an alternative to other DOD managed care programs and direct care from the MTF. USTF enrollees are neither direct care nor CHAMPUS eligible.
>
> If the specified patient is not assigned an ACV code of "U," the system allows you to continue the enrollment process without restriction. If the patient is assigned an ACV code of "U," the DEERS Eligibility Data screen displays with the message “This patient is a Uniformed Services Treatment Facility (USTF) enrollee who elected, in writing, to receive all non-emergency care from a USTF. Your facility is not reimbursed for care provided to this patient unless the USTF agrees to pay your facility prior to you rendering services to the patient.” The system does not allow the user to proceed with the enrollment as the beneficiary is currently enrolled in another program. DEERS will reject the enrollment.

If the DEERS link is down or unavailable, or if you or the system batch the DEERS eligibility check, the system bypasses the online DEERS eligibility check. You may enter enrollment data without the eligibility data but the enrollment may, and often is, rejected by DEERS for ineligibility or incorrect data. It is recommended that enrollments be entered only when the DEERS link is active.

```
                              FAMILY MEMBER SCREEN

    Patient Name: GRILLO,THERESA.                          FMP/SSN: 01/449-63-
7755
             DOB: 05 May 1991
    Sponsor Name: GRILLO,JOHN D                       Sponsor SSN: 449-63-7755
 Elig Start Date: 08 Aug 1989                      Elig End Date: INDEFINITE
-------------------------------------------------------------------------------
--
Name              Sex    DOB         DDS  ACV   Dir   Med  DMIS   ACV Start/End
-------------------------------------------------------------------------------
--
GRILLO,JOHN D     M      12Jun1975   20    N     E     N   0103   01Jun95-INDEF
GRILLO,THERESA    F      04May1991    1    C     E     N
GRILLO,JOHN       M      06Nov1993    2    E     E     N   7056   01Jun97-
31Dec97
GRILLO,THERESA    F      02Nov1964   30    E     E     N   7056   01Jun97-
31Dec97


-------------------------------------------------------------------------------
--
Use SELECT key to select the family member you are enrolling

or Press <RETURN> to enter an override code
```

Figure 5-3. Family Member Screen

Confirm the patient for enrollment

1. Select the family member you are enrolling or press <Return> to enter an override code. Position the cursor beside the family member you are enrolling, then press <Return>.

2. If the patient is ineligible for this enrollment, the system allows you to enter an override code and continue with the enrollment or to abort the enrollment and return to the *Select PATIENT NAME* prompt. Please note that though CHCS permits a user to collect and store enrollment information for an ineligible beneficiary, DEERS will reject the enrollment and it becomes invalid in CHCS. The beneficiary data must be corrected in DEERS in order for the beneficiary to be enrolled.

3. If the patient is eligible for enrollment or has had an override reason stipulated, the system allows you to process other family members from the list displayed. The system processes each family member selected as it did the first family member. For example, registration data will be input on the Mini Registration

screen for each family member to be enrolled, then the user may select and enroll those family members from the family member list.

F9 view of family members - Position the cursor next to the family member name and press <F9> prior to enrolling a family member to view which family members are currently registered in CHCS.

Select patients for enrollment processing

Reciprocal Enrollment/Disenrollment - If eligibility checks are batched during enrollment, CHCS will not determine that a reciprocal disenrollment is needed. Enrollment when DEERS is off-line is not recommended unless absolutely necessary.

After a family member is selected, CHCS checks the ACV and DMIS ID fields following the DEERS check. If the ACV field indicates a TRICARE enrollment ("A", "D", or "E") and if the DMIS ID field contains a code that does not match one or more of the codes of the requesting site, reciprocal enrollment/disenrollment processing is initiated.

1. If the DMIS ID Code of the facility where the beneficiary is currently enrolled does not match any of the local CHCS DMIS ID Codes; and if the beneficiary's ACV from DEERS is either A, TRICARE PRIME (Active Duty); D, MEDICARE DEMONSTRATION; or E, TRICARE PRIME (CHAMPUS), the following prompt displays: *FAMILY MEMBER [NAME] IS CURRENTLY ENROLLED AT [FACILITY]. DO YOU WISH TO DISENROLL FAMILY MEMBER [NAME] FROM [FACILITY] (EFFECTIVE ONE DAY PRIOR TO THE ENROLLMENT DATE) AND ENROLL [NAME] AT THIS FACILITY (Y/N)?.* You can then perform a Reciprocal Enroll/Disenrollment of the selected beneficiary. If you answer "N", the application exits without enrolling the beneficiary.

> **Note:** You may also disenroll a beneficiary from a remote facility without enrolling the beneficiary locally by using the Reciprocal Disenroll option on the Enrollment Menu.

CHCS/DEERS Discrepant Data - The system then displays the CHCS/DEERS Discrepant Data screen with a comparison of patient data from CHCS and DEERS, highlighting any discrepancies between the two systems. If you wish, you can print the MCP CHCS/DEERS Discrepancy Data Report. If discrepancies exist, you can update CHCS from DEERS to eliminate one or more of the discrepancies prior to enrollment. You cannot update the DEERS data.

> **Note:** It is extremely important to print and review the MCP CHCS/DEERS Discrepancy Data Report to ensure that all patients enrolled in CHCS are enrolled in DEERS. This report can be printed for errors occurring in any time period, past or present.

The system also performs a DEERS eligibility check on each beneficiary to determine whether the beneficiary is enrolled in a USTF plan. USTF enrollees are listed in the PAS DEERS Ineligibility Report. The system performs the DEERS eligibility check immediately after the beneficiary has been entered at the *Patient Name* prompt.

If the system recognizes the patient as a USTF enrollee and you accept the default to Continue to enroll the patient, the system checks the patient's ACV.

If the ACV is defined as U (Enrolled in USTF Managed Care), a message displays explaining that the patient is enrolled in a USTF and your facility will not be reimbursed for the care provided. A USTF enrollee may not be reciprocally disenrolled or enrolled in TRICARE Prime.

If a DEERS check has been performed on the patient within the past five days, Current DEERS Eligibility screen displays, then the CHCS/DEERS Discrepancy screen (if appropriate). If there are no discrepancies, the system bypasses the CHCS/DEERS Discrepancy screen and displays the Demographics Display screen. If the DEERS interface is down, CHCS displays a warning/information message, then displays the Demographics Display screen.

All enrollments are stored with an MCP status of "pending enrollment" until confirmation of acceptance or rejection is received from DEERS. If the DEERS link cannot be accessed, the eligibility check and the enrollment date are stored. If the DEERS link is down, once the interface is returned, the eligibility check is processed.

If DEERS confirms the patient is eligible, the MCP status is automatically updated to Enrolled.

If DEERS determines the patient is not eligible, the MCP status is automatically updated to Invalid Enrollment.

In addition to updating MCP status, a successful enrollment response triggers the system to update the ACV and DMIS ID. Successful enrollment responses also trigger the system to update the ACV start date and PCM Location Code based on data contained in the MCP Patient file.

If the eligibility checks are batched for active-duty enrollees, the end enrollment date is set to one year from the enrollment start date.

When the eligibility response is returned to CHCS for an active-duty enrollee with an eligibility end date of "indefinite," the enrollment end date is automatically updated to indefinite.

> **Note:** An enrollment that appears valid in CHCS, is not valid until it is valid in DEERS, even if an override is used for an eligible patient because the DEERS link is down. Batch enrollment is available in CHCS, but it is not recommended.

Current DEERS Eligibility Display - The Current DEERS Eligibility Display action is also invoked from the PCM Booking, Appointment Referral Booking, Non-Enrolled Booking, Enrollment Enter/Edit, Reciprocal Disenrollment Processing, or Non-Availability Statement Processing options. This action only occurs when the patient being processed has had a DEERS check performed within the last five days. Enrollment data from the DEERS system, up to five-days old, is displayed.

Enroll a patient who has had DEERS check

- **Data Entry Process**

The system proceeds to the Current DEERS Eligibility Display screen when the patient being processed has had a DEERS Check performed within the last five days. If an eligibility check has not been performed in the last five days, a new DEERS eligibility check is performed, which includes today's eligibility data.

The system prompts you to begin by displaying the first Current DEERS Eligibility screen and an action bar allowing you to view additional DEERS data, print a copy of the DEERS data for the selected patient, initiate/repeat a new DEERS check for today, or accept the information as shown and continue with the option process being performed when this DEERS check was invoked.

You may only create a current enrollment for the patient. A patient already enrolled, may not be disenrolled in the future and reenrolled under a new future status. For example, a patient is enrolled currently as active-duty, is retiring in the future, and wants to enroll as a retiree today. The future enrollment may be entered after the current enrollment terminates.

Access the EENR option

Select the patient name

Display five-day eligibility information

Display Current DEERS Eligibility, second screen

Display the Demographics Display screen

Access the EENR option

Select the patient name

Display five-day eligibility information

If a DEERS check has been performed on the selected patient within the past five days, the Current DEERS Eligibility screen displays showing the data from that transaction. Refer to Figure 5-4. Current DEERS Eligibility, page 5-19.

```
                        CURRENT DEERS ELIGIBILITY
            Name: TOMAZIN,MELINDA                FMP/SSN: 30/600-09-2997
Patient Category: USN FAM MBR AD                     DDS: 30
         DOB/Age: 07 Aug 1968/29Y                    Sex: FEMALE
_____________________________________________________________________________
            Sponsor Rank: CAPTAIN
             Sponsor UIC: N35672-NAS OCEANA
                 DMIS ID: 0124-NH PORTSMOUTH
                     ACV: E-MCP ENROLLED/DIR. CARE CHAMPUS ELIGIBLE
          ACV Start Date: 01 Nov 1995       Region Code: 02
  Care Authorization PH#: 0000000000      PCM Location: DIRECT CARE PC
             Direct Care: ELIGIBLE            Medicare: NOT ELIGIBLE
Dir Care Elig Start Date: 30 Sep 1995          CHAMPUS: ELIGIBLE
  Dir Care Elig End Date: 21 Jan 1998
  Eligibility End Reason: P-ID Card Expiration

                              BRAC Pharmacy Eligibility:
          Override Code:
         Date of Request: 12 Nov 1997@1433
_____________________________________________________________________________
Select to(V)iew more DEERS data,(P)rint,(R)epeat DEERS check,(C)ontinue,
       or (Q)uit: C//
```

Figure 5-4. Current DEERS Eligibility

Actions on the Current DEERS Eligibility action bar are as follows:

- **(V)iew more DEERS -** Displays a second screen containing the remainder of the DEERS data for the selected patient. After viewing the data, press <Return> to return to the Current DEERS Eligibility screen and action bar.

- **(P)rint -** Prints a copy of the data on the initial Current DEERS Eligibility screen and the second Current DEERS Eligibility screen. You also must enter a printer name and press <Return> at the *RIGHT MARGIN: 80//* prompt. If you press <Return> at the *Select DEVICE* prompt, the first screen displays on your terminal screen. When you finish viewing the first screen, press <Return> to view the second screen. After printing the data, the system returns to the initial Current DEERS Eligibility screen and action bar.

- **(R)epeat DEERS check -** Invokes a new online DEERS check for the patient. DEERS must be online to perform this action. When the DEERS check is complete, the system proceeds to the next action in the option process being performed when this DEERS check was invoked. This action displays only for a new enrollment, not for an existing enrollment.

- **(C)ontinue -** Proceed to the next action within the option being processed. This is the default.

- **(Q)uit -** Exit the option without further processing.

Display Current DEERS Eligibility, second screen

Enter V to view more DEERS data. Refer to Figure 5-5. Current DEERS Eligibility, Second Screen, page 5-20.

```
                        CURRENT DEERS ELIGIBILITY
            Name: TOMAZIN,MELINDA                FMP/SSN: 30/600-09-2997
Patient Category: USN FAM MBR AD                     DDS: 30
         DOB/Age: 07 Aug 1968/29Y                    Sex: FEMALE

-------------------------------------------------------------------------

CHAMPUS Dental Flag: 1-INDIVIDUAL COVERAGE
   Dental Start Date: 01 Dec 1995       Dental End Date: INDEFINITE
   Date Last Updated: 14 Jul 1997        Panograph Date: 29 Jan 1991
           NAS Flag:                        Organ Donor: YES
Reportable Disease                               DNA: YES
Database (RDDB) Date: 22 Oct 1997
     Date of Request:

-------------------------------------------------------------------------

Press <RETURN> to continue
```

Figure 5-5. Current DEERS Eligibility, Second Screen

Press <Return> after viewing this screen. If there are no data discrepancies between CHCS and DEERS, you return to the original DEERS Eligibility screen. Refer to Figure 5-4. Current DEERS Eligibility, page 5-19.

Display Demographics Display screen

Enter C to continue. The Demographics Display screen displays. Refer to Figure 5-6. Demographics Display Screen, page 5-21.

```
                          DEMOGRAPHICS DISPLAY
           Name: TOMAZIN,MELINDA              FMP/SSN: 30/600-09-2997
Patient Category: USN FAM MBR AD                  DDS: 30
    Patient Type:                                 Sex: FEMALE
      MCP Status:                             DOB/Age: 07 Aug 1968/29Y
             ACV: E-MCP ENROLLED/DIR. CARE CHA DMIS ID:
     Direct Care: ELIGIBLE                   Medicare: NOT ELIGIBLE
_____________________________________________________________________________
          Sponsor Name: TOMAZIN,MICHAEL           Rank: CAPTAIN
          Station/Unit: NAS OCEANA                 DSN:
          Home Address: 1916 WOOD GATE ARCH
                  City: CHESAPEAKE              State: VIRGINIA
              ZIP Code: 23320              Home Phone: 8044203584
            Duty Phone:                    Work Phone:
  Registration Comment:
Last Registration Date: 12 Nov 1997@143504
Outpatient Record Room:
       MCP Enroll Date:                    End Enroll Date:
  Primary Care Manager:                         PCM Phone:
          Primary OHI: NOT ASSIGNED             Case Mgmt:
_____________________________________________________________________________
Select (F)ull, (M)ini, (E)nrollment, (O)HI, (N)ew Patient,
       or (Q)uit DEMOGRAPHICS: E//
```

Figure 5-6. Demographics Display Screen

Actions on the Demographics Display action bar are as follows:

- **(F)ull -** Enter or edit full registration.
- **(M)ini -** Enter or edit mini registration.
- **(E)nrollment -** Enrolls the current patient and/or family members, edits an existing enrollment, enters or edits patient PCM data, enters or edits exception or CASE providers, disenrolls current patient or family members.
- **(O)HI -** Enters or edits health insurance policies.
- **(N)ew Patient -** Aborts the current patient record and returns you to the *Select Patient* prompt.
- **(R)enew -** Renews an existing enrollment. This action is available only if the patient is not active-duty.
- **(Q)uit Demographics -** Exits the Demographics Display screen.

Correct CHCS/DEERS data discrepancies

CHCS/DEERS Discrepant Data Check - The CHCS/DEERS Discrepant Data Check action is automatically invoked following a normal DEERS eligibility check for all MCP patients, all non-availability statement (NAS) requests, all first time registered Patient Appointment and Scheduling (PAS) patients, and all admissions processing of patients. This action is also automatically invoked after an interactive DEERS eligibility check is requested.

After completing the CHCS/DEERS discrepancy data check, the results of the check display with discrepancies highlighted between the CHCS data on file and the DEERS data just received. The system then allows you to selectively update the CHCS file with the data shown in DEERS and/or print the discrepancy screen showing the DEERS and CHCS entries.

An entitlement discrepancy occurs when a beneficiary’s eligibility changes after enrollment, (e.g., enrollee separates from service). You may clear an entitlement discrepancy indicator with this screen. However, if the entitlement discrepancy is not corrected, the indicator reappears during the next eligibility check. Clearing the enrollment discrepancy does not change the MCP patient status if the patient's status is Invalid Enrollment or Invalid Disenrollment, nor does it correct the patient's ACV on DEERS. You can only make these changes through the enrollment and disenrollment options. Entitlement discrepancies may be viewed on the Enrollee Entitlement Discrepancy Report (Menu Path: PAS System Menu → M → OMCP → ERME → ROST → 10).

- **Data Entry Process**

Clear entitlement discrepancy

Select CHCS data to correct

Confirm correction of CHCS data to match DEERS

Correct UIC in DEERS

Clear entitlement discrepancy

Refer to Section 4.5.

Select CHCS data to correct

Refer to Section 4.5.

Confirm correction of CHCS data to match DEERS

Refer to Section 4.5.

Correct UIC in DEERS

Refer to Section 4.5.

CHCS DEERS Discrepancy Data screen - The system automatically initiates the CHCS/DEERS Discrepant Data Check action following the Interactive DEERS Eligibility Check within MCP options for first time registered patients and for all patients being processed for admissions. It is not initiated for existing patients.

The system begins by displaying the patient data found in CHCS and the patient data found in DEERS and highlighting the discrepancies. The system then displays an action bar allowing you to update CHCS data from DEERS, print discrepancies, clear entitlement discrepancies, continue, or quit processing. Refer to Figure 5-7. CHCS/DEERS Discrepancy Data Screen, page 5-24.

If you elect to continue processing, the system proceeds to the next step in the option being processed (normally the Demographics Display screen). If you elect to quit, the system exits the option in process.

> **Note:** The CHCS/DEERS Discrepancy Data screen also displays in PAS and NAS processing if eligibility data discrepancies are detected during the initial patient registration.

```
                        CHCS/DEERS DISCREPANCY DATA
             Name: GRILLO,THERESA                    FMP/SSN: 01/449-63-7755
  Patient Category: US FAM MBR AD                        DDS:  1
       MCP Status:                                    DOB/Age: 04 May 1991/06Y
              ACV:                                    DMIS ID:
      Direct Care: ELIGIBLE                         Medicare: NOT ELIGIBLE
-------------------------------------------------------------------------
                    CHCS Data                      DEERS Data
_________________________________________________________________________
_

             Name: GRILLO,THERESA                  GRILLO,THERESA
              DOB: 05 May 1991                     04 May 1991
              Sex: FEMALE                          FEMALE
       Patient SSN: 810-97-0415                    810-97-0415

      Sponsor Rank: FIRST LIEUTENANT               CAPTAIN
     Patcat/Status: A31-RETIRED                    ACTIVE-DUTY
      Station/Unit: FF58B-1912 COMPUTER SYSTEMS    FF58B

Select (U)pdate CHCS, (P)rint Discrepancies, (C)ontinue, or (Q)uit: U//
```

Figure 5-7. CHCS/DEERS Discrepancy Data Screen

If you select the Update CHCS action, the cursor is positioned next to the first data element that may be selected. You may select the data elements to update, make the correction(s), and file the data. The system updates the selected CHCS patient data to match the DEERS data. You may not update DEERS data during discrepancy processing.

> **Note:** If there are discrepancies between DEERS data and CHCS data, the enrollment may be rejected.

Updating patient data in CHCS is subject to the following rules:

- Only discrepant data is considered for change. If no data discrepancies are detected, the discrepancy screen does not display.
- You cannot update the patient's SSN if the patient is a sponsor. You can only make such an update using the Mini Registration or Full Registration options.
- The unit identification code (UIC) sent from DEERS must exist as a standard entry in the CHCS Unit Ship ID file.
- The sponsor rank sent from DEERS does not match the ranks used by CHCS and must be resolved by the user on this screen.
- The UIC and sponsor rank are changed interactively in the sponsor record via the discrepancy screen.
- If the patient is currently an inpatient, the DOB, Sex, and Sponsor Rank fields cannot be changed at the discrepancy screen. These fields are for display only. You can only make these changes using the Mini Registration or Full Registration options.
- If the patient has ever been an inpatient, the DOB and Sex fields cannot be changed at the discrepancy screen. These fields are for display only. You can make these changes using only the Patient Administration (PAD) Corrections Management functionality.
- All changes must pass standard checks for format consistency.

Sponsor Rank - If the selected data element is the Sponsor Rank, the CHCS-stored rank displays and you can enter a new rank from the CHCS Rank Table.

UIC Code - If the selected data element is the UIC code, the cursor is positioned directly after the *Station/Unit [Current Station/Unit]* prompt. When you enter a UIC code, refer to the standard UIC tables. Do not enter a new code. If you do not know the UIC, you can enter the ZIP Code to display a help list of the UICs in that ZIP Code area.

Enrollee Entitlement Changes Resulting in Discrepancies - When a beneficiary's eligibility changes after enrollment, the change is detected after the DEERS eligibility check has been performed. The patient record is marked with one of the following entitlement discrepancy flags:

1 Sponsor No Longer Active-Duty
2 No Longer CHAMPUS Eligible
3 Sponsor Retired
4 No Longer Medicare Eligible
5 Became Medicare Eligible
6 Became CHAMPUS Eligible
7 Possible Active-Duty PCS

In order to clear the discrepancy, the patient must be disenrolled from MCP. The disenrollment and reciprocal disenrollment processes clear the Entitlement Discrepancy field at the time the disenrollment is filed. If the patient is reenrolled, the enrollment start date is compared to the ACV End Date from the previous enrollment episode to prevent overlapping enrollment episodes. The Enrollment Entitlement Discrepancy Report lists all enrollees with entitlement discrepancies.

The DEERS Eligibility Data screen - The DEERS Eligibility Data screen displays immediately after an individual eligibility check and contains the actual data from the DEERS database which is current as of that day. Refer to Figure 5-8. Sample DEERS Eligibility Data Screen for an Eligible Patient, page 5-26.

```
                          DEERS ELIGIBILITY DATA

                  Name: PEARL,ZACHARY N             FMP/SSN: 20/569-59-4415
       Patient Category: USN ACTIVE-DUTY                DDS:
                DOB/Age: 12 Jun 1975/26Y                Sex:
-------------------------------------------------------------------------
                  NAME: PEARL,ZACHARY N
                   SEX: MALE                            DOB: 12 Jun 1975
                   DDS: 20                       Sponsor SSN: 569-69-4415
                   ACV: N-NOT ENROLLED/CHAMPUS INELIGIBLE
         ACV Start Date: 30 Oct 1999              Region Code:
                DMIS ID: 0037-Walter Reed AMC
  Care Authorization PH#:                        PCM Location:
            Sponsor Rank:
             Sponsor UIC:
             Direct Care: ELIGIBLE                   Medicare: NOT ELIGIBLE
Dir Care Elig Start Date: 25 Sep 1998                 CHAMPUS:
  Dir Care Elig End Date: 17 Mar 2004
  Eligibility End Reason:

BRAC Pharmacy Eligibility:
-------------------------------------------------------------------------
Select to (V)iew more DEERS data, (H)istorical DEERS, (P)rint, (C)ontinue,
       or (Q)uit: C//
```

Figure 5-8. Sample DEERS Eligibility Data Screen for an Eligible Patient

Recent changes/additions to the DEERS Eligibility Data screen fields include:

– Care Authorization PH# has been added. This is the 24-hour phone number to reach a PCM.

– Elig Start Date is now ‘Dir Care Elig Start Date.’

– Elig End Date is now ‘Dir Care Elig End Date.’

- Eligibility Comment is now ‘Eligibility End Reason.’
- SSN is now ‘Sponsor SSN.’
- Region Code has been added. This is the region where the beneficiary is enrolled, if enrolled.
- PCM Location has been added. This indicates whether the PCM is a direct care PCM (00) or a contractor PCM (01).
- BRAC Pharmacy Eligibility has been added.

DEERS Eligibility Data screen action bar - An action bar containing the following actions displays:

- **(V)iew More DEERS Data -** Review additional data received from DEERS. An additional DEERS data screen displays. Information on this screen includes whether the patient has CHAMPUS Dental care, the date this eligibility information was last updated, a Panograph date, whether the patient is an organ donor, whether the patient has reportable diseases (yes or no), and the date of the request.

  Press <Return> at this screen to redisplay the first DEERS Eligibility Data screen with the action bar.

- **(H)istorical DEERS -** Displays each eligibility segment for the individual. The eligibility segments cover two years prior to and six months into the future as the default.

- **(O)verride Ineligibility -** Allows you to enter an override code if the patient's Direct Care eligibility is Not Eligible. This only allows an enrollment to be recorded in CHCS; it will not be recorded in DEERS as it will be rejected. This option appears on the action bar only if the Direct Care Eligibility code indicates Not Eligible, with a message stating “Patient Ineligible.”

  If you elect to override, you are required to enter an override code to continue. Enter a question mark (?) to display valid override codes. If you elect not to override, you must quit the option.

- **(P)rint -** Prints all eligibility information, including the historical data if available. The system prompts for a Device, then prints the report. The report includes information from the DEERS Eligibility Data screen, the additional DEERS Eligibility data screen, as well as the Historical DEERS Eligibility Data screen.

- **(C)ontinue -** Continue with the process from which the user entered the DEERS eligibility check.

- **(Q)uit -** Exit the screen and the enrollment process.

DEERS Link Unavailable - When eligibility data is not available and the site is operating in the DEERS Enrollment mode, the site interprets eligibility based on the enrollment transaction response.

When the site is operating in Local Empanelment mode and eligibility is batch processed, the system later evaluates the MCP status based on the eligibility response when received. The ACV field identifies a nonenrolled patient as N - NOT ENROLLED/CHAMPUS INELIGIBLE (active-duty or non-CHAMPUS) or C-CHAMPUS eligible (CHAMPUS eligible and direct care eligible).

CHCS generates the ACV based on the beneficiary's patient category, age and other factors. The ACV field reflects the type of eligibility for the patient. A complete list of ACV codes is provided where the MCP Enrollment – Continuation screen is discussed. This field cannot be changed by the user. The patient category must be correct, or the enrollment may be rejected by DEERS. The ACV may be corrected by changing the patient category or by changing the patient type value. Refer to Table 5-2. Valid Patient Type Codes, page 5-44, for a list of valid ACV codes.

The Mini Registration screen displays. Refer to Figure 5-9. Mini Registration Screen, page 5-30.

Full Registration or Mini Registration

- **Data Entry Process**

Mini Registration

Complete the Allergy screen

Enrollment

- **Active-Duty Auto Enrollment**
- **Select the Enrollment action on the Demographics Display action bar**
- **Enroll the Beneficiary**
- **Complete the first MCP Enrollment - Continuation screen**
- **Complete the second MCP Enrollment screen**
- **Select a PCM**

Full Registration - If you elect to enter the Full Registration option, the system prompts you to modify the patient's current registration. Then the system returns to the action bar.

Mini Registration - If you elect to enter the Mini Registration option, the system prompts you to modify the registration. The system then returns to the action bar. When entering a new registration, the following fields contain the same data from the DEERS eligibility check: sex, patient address, DOB and sponsor SSN. This is the only time DEERS addresses and other data may be viewed in CHCS.

Mini Registration

```
     Patient: PEARL,ZACHARY N.                              Mini Registration
     FMP/SSN: 20/569-69-4415       DOB: 12Jun75        PATCAT: N11    Sex: M
                Personal Data - Privacy Act of 1974 (PL 93-579)

     Patient: PEARL,ZACHARY N.                          DOB: 12 Jun 1975
      PATCAT: N11 (USN ACTIVE-DUTY)                     FMP: 20
  Home Phone: 974-2333        W:                       SSN: 569-69-4415
Patient Addr: 1020 NEWPORT DRIVE                       Sex: MALE
        City: HAMPTON               St/Cntry: VA       Zip: 23665

     Sponsor: PEARL,ZACHARY N.                    Service: NAVY
         FMP: 20                               Sponsor SSN: 569-69-4415
      PATCAT: N11 (USN ACTIVE-DUTY)                     DOB: 12 Jun 1975
 Command Sec:                                          Rank:
Station/Unit:
Duty Address:
        City:                       St/Cntry:          Zip:
  Duty Phone:                                          DSN:

 O/P Rec Loc:
 O/S Rec Loc:
 Primary Phy:
 Reg Comment:

Help = HELP      Exit = F10     File/Exit = DO                INSERT OFF
```

Figure 5-9. Mini Registration Screen

Much of the information displayed on this screen is automatically entered from previous screens. The demographic data is transferred from the selected family member. For a new registration, the displayed data is defaulted from DEERS data in the eligibility information.

This screen contains both patient information (top portion and bottom portion) and sponsor information (middle portion).

1. Home Phone

   This field is automatically entered with the patient's home phone number from DEERS on a new registration and from CHCS for an existing registration. Press <Return> to accept the data, or enter new data. Changes to this data updates DEERS.

2. Work Phone

   Enter the patient's work phone or press <Return> to leave this field blank. Changes to this data updates DEERS.

3. Patient Address

   This field is automatically entered with the patient's address from DEERS for a new registration and from CHCS for an existing registration. Press <Return> to accept the data, or enter new data. Changes to this data updates DEERS.

4. Sex

   This field is automatically entered with the patient's sex from DEERS for a new registration and from CHCS for an existing registration. Press <Return> to accept the data, or enter new data.

5. ZIP

   This field is automatically entered with the patient's ZIP code from DEERS for a new registration and from CHCS for an existing registration. Press <Return> to accept the data, or enter new data. Changes to this data updates DEERS.

The following fields are automatically entered with the sponsor's information (if the sponsor's registration in CHCS contains this information):

- Sponsor
- FMP
- Sponsor SSN
- PATCAT
- DOB
- Command Security
- Rank
- Station/Unit
- Duty Address
- City
- St/Cntry
- ZIP
- Duty Phone
- DSN

6. Service

   This field is automatically entered with the sponsor's service.

7. Sponsor SSN

   This field is automatically entered with the sponsor's Social Security number.

8. Command Security

   Not a required field; however, you should complete this field if the sponsor is designated as a member of one of the following security programs:

   – Personnel Reliability Program (PRP)

   – Presidential Support Program (PSP)

   – Sensitive Compartmented Information (SCI).

   The information contained in this field flags the system to list this patient on the daily Command Security Report. The Command Security Report lists any designated active-duty patient who had an appointment on the previous day. Enter a double question mark (??) to view more information on completing this field

9. Sponsor Rank

10. Station/Unit

    If the system cannot locate within the UIC table, the name of the station/unit that you have just entered, the system provides an opportunity to display the list of station/units in the UIC table. You must enter a station/unit already contained in the UIC table.

    You can also enter the ZIP code to display a picklist of UICs located in the ZIP code area.

11. Confirm Station/Unit

12. Duty Address.

13. ZIP

    The City and State fields are automatically entered based on the ZIP code entered.

14. Duty Phone

15. DSN

    Enter the sponsor's Defense Switching Network (DSN) number or prefix.

16. O/P Rec Location

    You must enter an outpatient record (O/P) location for the patient's records.

    If the O/P Rec Loc field is left blank, the *Patient Record Room Missing* prompt displays at the bottom of the Demographics Display screen. You must either enter a record room in the O/P Rec Loc field or create a medical record for this patient before continuing with the enrollment process.

17. O/S Record Location

    O/S stands for off-site. If the outpatient record has not been created using the Medical Record Tracking software, you may enter information regarding the actual whereabouts of the records in the O/S Rec LOC field, using 3 to 65 characters. This information helps complete the paperwork in the record file and account for records not found in any of the hospital record locations.

18. Primary Physician

19. Registration Comment

20. Does [patient] want to be an organ donor?

    This is an optional field and can be left blank. Check your site policy regarding this field.

Note: If you answer Y or N, an address update/organ donor transaction is sent in the background to DEERS to record the patient's wishes regarding organ donation.

21. File the data.

    If the patient has an ACV of C or N, a prompt displays at this point asking if you want to view the enrollment information. If you accept the “N” default for NO, the system exits the Mini Registration option. If you enter “Y” for YES, the Enrollment/Empanelment Information screen displays the enrollment data from DEERS.

If the patient has an ACV of A, D, or E, the Enrollment/Empanelment Information screen displays with additional information about the patient. In addition to the PCM Name, PCM Location, PCM Phone, and Medicare eligibility status fields displayed in CHCS V4.5, the Enrollment/Empanelment Information screen now displays the region code, date of the last eligibility check, eligibility, and the eligibility start/stop dates. Refer to Figure 5-10. Enrollment/Empanelment Information Screen, page 5-34.

```
Patient: PEARL,ZACHARY                Enrollment/Empanelment Information
FMP/SSN: 20/569-69-4415     DOB: 12Jun75     PATCAT: N11           Sex: M
               Personal Data - Privacy Act of 1974 (PL 93-579)

                      ACV: A-TRICARE PRIME (ACTIVE-DUTY)
                   DMIS ID: 0125-MADIGAN AMC
                  PCM Name:
                 PCM Phone:
              PCM Location:
                  Medicare: NOT ELIGIBLE
                Region Code: 11
                Direct Care: ELIGIBLE
                    CHAMPUS:
  Dir Care Elig Start Date: 25 Sep 2001
   Dir Care Elig Stop Date: 17 Mar 2004
     Last DEERS Elig Check:




Press <RETURN> to continue
```

Figure 5-10. Enrollment/Empanelment Information Screen

- **PCM Name -** If the patient is not locally empaneled, and the information has been downloaded from DEERS, the PCM name does not display.

- **PCM Phone -** The phone number of the 24-hour line to reach the PCM.

- **PCM Location -** CHCS sets a PCM location code in the enrollment transaction based on the type of PCM assigned to the enrollee. The code “00” indicates a direct care PCM and “01” indicates a contractor PCM. Contractor systems that enroll also create this data and send it to DEERS.

- **Medicare -** Whether patient is Medicare eligible.

- **Region Code -** The Department of Defense (DOD) region associated with the patient's DMIS ID as recorded in the DEERS database. It is populated by a DEERS eligibility check transaction.

Note: The DOD region is an attribute of DMIS ID. However, because of differences scheduling data updates, the DOD region reported for a given DMIS ID may be different within the DMIS ID CODES file (file #8103) in CHCS from those within the DEERS database.

- **Direct Care -** Whether the patient is eligible for direct care.
- **CHAMPUS -** Whether the patient is CHAMPUS-eligible or foreign military.
- **Dir Care Elig Start Date -** If the patient is eligible for direct care, the system enters the start date here.
- **Dir Care Elig Stop Date -** If the patient is eligible for direct care, the system enters the date direct care eligibility ends.
- **Last DEERS Elig Check -** The date a DEERS eligibility check was last performed for this patient.

22. Press <Return> to continue when you have finished viewing the Enrollment/Empanelment Information screen.

23. Enter/Edit Allergy Information?

    You may press <Return> to accept the default or enter Y(ES) to edit the patient's allergy data. If you enter Y(ES) the patient's Allergy Enter/Edit screen displays. Refer to Figure 5-11. Allergy Enter/Edit Screen, page 5-36.

    The complete list of allergies and allergy comments entered for this patient displays whenever a health care provider (HCP) enters RX or MED as an order type through order entry. The HCP can proceed to order the desired medication, but receives a warning that must be overridden and a reason for overriding the warning must be entered.

Complete the Allergy screen

```
PEARL,ZACHARY N                 20/569-69-4415  26y M   CPO   Allergy
Enter/Edit
================================================================================
=
Allergy:
BARBITURATES

Comment:
HIVES




 Help = HELP      Exit = F10     File/Exit = DO                      INSERT OFF
```

Figure 5-11. Allergy Enter/Edit Screen

Repeat Steps 1 and 2 for each allergy entered.

1. Allergy

   A patient's allergy can be an allergy class, a brand name, a generic name, or an ingredient not marketed separately (e.g., Imipenem). If you need help, enter a double question mark (??) to display a picklist of allergies. This allergy picklist is the First Data Bank (FDB) list, which is updated at each site quarterly.

   Press <Next Screen> several times to scroll through the list or quit to exit the picklist.

   If the patient's allergy is not on the FDB list, enter OTHER and specify the allergy in the comments field.

2. Allergy Comment

   The comment field is usually used to document the severity of the allergy or the symptoms the patient describes.

   You can enter additional allergies, if required.

3. File the data.

   Press <Return> to continue.

Active-Duty Auto Enrollment

The option to automatically enroll a patient into MCP is only available when entering or editing a mini registration for an active-duty patient who has never been enrolled in MCP. You must also hold the CPZ ENROLL security key to automatically enroll active-duty patients.

1. Enroll in Managed Care?

   If you answer Y and the patient is active-duty, the Active-Duty Auto-Enrollment screen displays. Refer to Figure 5-12. Active-Duty Auto Enrollment Screen.

```
                    ACTIVE-DUTY AUTO ENROLLMENT

     Patient Name: PEARL,ZACHARY                FMP/SSN: 20/569-69-4415
       MCP Status:
_____________________________________________________________________________

      Station/Unit: 0003 AR RGT     AR CAV REGT
Enrolling Division: OUTPATIENT DIV
       Default PCM: ROBERTS,KRAMER
    Agreement Type: MTF
   Max AD Capacity: 10
     # AD Assigned: 6
   Enrollment Date: 20 Oct 1997
_____________________________________________________________________________

Accept default PCM? Yes//
```

Figure 5-12. Active-Duty Auto Enrollment Screen

1. Press <Return> to accept the default PCM or enter N.

   If you accept the default PCM, the following message displays:

   ```
   Enrolling in MCP...
   ```

   and displays the *Display/Print PCM and place of care? NO//* prompt. If you enter Y at this prompt, you are prompted to enter a printer name (device) to print the PCM's address, phone number, and hours of service.

   If you enter N at the *Accept default PCM? Yes//* prompt, the system then prompts you to enter a specific PCM.

For the remainder of this example, complete MCP enrollment is performed rather than automatic enrollment.

Select the Enrollment action on the Demographics Display action bar

The first MCP Enrollment – Continuation screen displays. Refer to Figure 5-13. MCP Enrollment - Continuation Screen, page 5-43.

> **Note:** If enrollment is restricted by residential address, and the patient you are enrolling is not within the catchment area, the following message displays *"-Invalid Patient ZIP CODE, location is not within Catchment Area*". The following message also displays to holders of the CPZ ZIP security key - "*Do you want to override? No//."* Authorized users may select to override the restriction and continue with the enrollment. Otherwise, you should request that the system administrator add the ZIP code to the Catchment Area Table.

Enroll the Beneficiary

The MCP Enrollment - Continuation screen is the primary enrollment screen.

The fields in the top Display Window are filled in with data from the patient's previously entered MCP demographics information in CHCS. This information is for display only and cannot be edited. If the patient's enrollment is not recorded in CHCS, the data does not show enrollment information from DEERS.

The fields in the bottom portion of the screen can be edited.

MCP Status Field - In the top portion of the screen, the MCP Status field is blank for those patients who have not been enrolled. This field is for display only and cannot be edited for those patients already enrolled. Refer to Table 5-1. Valid MCP Codes, page 5-39, for valid MCP status descriptions and status codes.

Table 5-1. Valid MCP Codes

Code	Status
C	Conditional Enrollment
D	Disenrolled
E	Enrolled
IE	Invalid Enrollment
ID	Invalid Disenrollment
PE	Pending Enrollment

The system uses the following conditions and rules to derive the specific status to assign to each patient:

- **Conditional Enrollment** - If the patient is a newborn (less than 1 year old, FMP 01-19) or a new spouse (FMP 30-39) and is not registered in DEERS and you choose to override the ineligibility, the MCP status displays as Conditional Enrollment. All other ineligible beneficiaries cannot be enrolled and are rejected by DEERS. Conditional enrollments are stored in a suspense file in DEERS and are set up as an enrollment when eligibility is confirmed. CHCS allows conditional enrollments for new spouses, but DEERS does not, so avoid entering conditional enrollments for other than newborns.

- **Pending Enrollment** - All enrollments are initially set to the pending status until confirmed or rejected by DEERS.

- **Disenrolled** - If a patient has been formerly enrolled in CHCS and is now disenrolled, the MCP status displays as Disenrolled. However, the enrollment ACV and DMIS ID still display on enrollment screens to indicate the previous enrollment status. If the response from DEERS is delayed (for example, if the DEERS line is busy and the inquiry must be batched), the MCP status is Invalid Disenrollment until processed by DEERS. Once validated by DEERS, the MCP status is updated to Disenrolled.

- **Enrolled** - Four conditions must be met for a patient to be assigned the Enrolled status:

  - A response of eligible must be received from DEERS (indicates eligibility on the enrollment start date).

- The MCP Enrollment screens must be completed and filed.
- A PCM must be assigned to the patient.
- MCP enroll date must be a past or current date. Enrollments with a future date remain pending until that date.

  Status until the CP Enrollment Bulletin determines the enrollment was not accepted by DEERS.

– **Invalid Enrollment** - If a discrepancy or ineligibility response is received from DEERS as a result of filing a patient's enrollment, the MCP status is changed within seconds to Invalid Enrollment. You may correct the patient data, then reenter the enrollment screen for this patient to retransmit data to DEERS and file the data. This action retransmits the enrollment transaction to DEERS with the corrections. Only invalid enrollments may be retransmitted to DEERS. This status remains until all the discrepancies are corrected, then the MCP status is changed to Enrolled.

– **Invalid Disenrollment** - If the system receives a discrepancy response from DEERS after sending the Disenrollment transaction or if the DEERS response is delayed, the MCP status displays as Invalid Disenrollment. This status remains until the discrepancies are corrected or until the delayed DEERS response is received; then the MCP status is changed to Disenrolled. You may correct this record and file the data. This action retransmits the Disenrollment to DEERS with the corrections. **Note:** If patient ID data is changed in CHCS after enrollment, the Disenrollment is rejected as DEERS no longer recognizes the enrollee. Return the data temporarily to the enrollment ID and retransmit. The discrepancy code received from DEERS can be viewed through the Print/Display Enrollment History (PENR) option.

ACV Field - The ACV defines the type of eligibility for the patient. Refer to Appendix A, ACV Codes. CHCS derives an ACV based on the Patient Category, CHAMPUS eligibility from DEERS, and age, then sends the derived value to DEERS as part of the enrollment transaction.

If DEERS disagrees with the CHCS-derived ACV, the enrollment is rejected and the MCP status is updated to “Invalid Enrollment.” Enrollment status is updated when an enrollment transaction is received from DEERS. The beneficiary appears on the Enrollment Discrepancy Report with the DEERS reason for the rejection. The discrepancy can then be resolved (based on the reason provided on the report) and the enrollment transaction can be retransmitted to DEERS.

The ACV field, located on the top portion of the screen, is for display only and cannot be edited directly.

The MCP patient type may be changed in certain circumstances to correct the ACV assigned; e.g., from MCP DIRECT CARE to MCP CHAMPUS to change the ACV to "E" for TRICARE enrollment provided the patient is CHAMPUS eligible.

> **Note:** The CP Enrollment Bulletin runs each night in order to validate the patient's current status and the success of the enrollment.
>
> **Note:** CHCS only uses codes A, E, C, D, and N (described below). Additional codes identify other DOD benefit programs.

The following ACV codes can be generated in the ACV field by CHCS during the enrollment process (you cannot enter data in this field):

A – The specified patient is active-duty and is currently enrolled in TRICARE Prime.

B – CHAMPVA (OCONUS)

C – The specified CHAMPUS eligible patient is covered under TRICARE Standard and is an active-duty family member, retired family member, or retiree under the age of 65 who is not enrolled in MCP. The ACV code is changed to "E" by the system after the patient is enrolled in TRICARE Prime.

D – The specified patient is over 65, Medicare eligible, and is enrolled in TRICARE Senior option.

E – Indicates the specified CHAMPUS eligible patient is enrolled in TRICARE Prime and is an active-duty family member, retired family member, or retiree under the age of 65. Patients can have dual eligibility, that is, they can be CHAMPUS eligible, an active-duty dependent (spouse), and also be Medicare eligible. CHAMPUS eligibility has priority and they should be assigned an "E".

K – Catchment Area Mgt

N – Indicates the patient (if active-duty, Medicare eligible or CHAMPUS Ineligible) is direct care eligible only. The code includes active-duty not yet enrolled. The system assigns the ACV code of "D" or "A" (whichever is applicable) after the patient has been enrolled.

***S** – CHCBP (CONT HLTH CARE BEN PROG)

U – USTF (UNIF SERV TREAT FACIL)

***V** – CHAMPVA (CONUS)

* These codes are not used in CHCS enrollment functionality because they represent other non-TRICARE-related programs. You may see these codes, however, when processing an eligibility request for a patient.

Note: After the enrollment data is filed and a PCM has been assigned to the patient, the enrollment transaction is sent to DEERS. DEERS then sends a response back to CHCS. If a discrepancy response is received by CHCS, an Enrollment/Disenrollment Discrepancy Bulletin is generated for this patient. Local empanelment mode does not control active-duty or Medicare enrollment processing; all active-duty and Medicare enrollments are sent to DEERS and recorded there, regardless of the value of the mode.

```
ENROLLMENT HISTORY: 01 Nov 1997                    MCP Enrollment -- CONTINUATION


                 Name: PEARL,ZACHARY                       FMP/SSN: 20/569-69-
4415
     Patient Category: USN ACTIVE-DUTY                         DDS:
         Patient Type: AD/ACTIVE-DUTY                          Sex: MALE
           MCP Status:                                     DOB/Age: 12 Jun
1975/26Y
 Primary Care Manager:                                   PCM Phone:
          Primary OHI: NOT ASSIGNED                      Case Mgmt: NO
                  ACV: A-TRICARE PRIME (ACTIVE-DUTY) Direct Care: ELIGIB LE
   Enrolling Division:                                    Medicare: NOT ELIGIBLE
 ================================================================================

         Patient Type: AD/ACTIVE-DUTY

      MCP Enroll Date: 01 Nov 1998
      End Enroll Date: 31 Oct 2000

   Enrollment Comment:


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO          INSERT OFF
```

Figure 5-13. MCP Enrollment - Continuation Screen

Complete the first MCP Enrollment - Continuation screen

The Enrolling Division field remains blank until a PCM is assigned. As soon as a PCM is assigned, the patient's Enrolling Division is designated as the PCM place of care. A division has a Medical Expense and Performance Reporting System (MEPRS) code and unique DMIS ID assigned to it for workload reporting. The DMIS ID is stored in DEERS to indicate where the beneficiary is enrolled. You cannot edit the Enrolling Division field at this screen.

> **Note:** Prior to CHCS Version 4.6, the Enrolling Division field was automatically entered with the name of the current user's division rather than the PCM place of care.

1. Patient Type

   If no DEERS response is received, the patient type is derived by the system based on the patient's PATCAT, ACV code, and age. The patient type cannot be edited

for an active-duty patient. Only the patient type for a non-active-duty patient can be changed.

Following is a list of patient types and descriptions used in MCP. These types are only used during the enrollment process if you override the CHCS derived patient type. Refer to the ACV section for more information.

Table 5-2. Valid Patient Type Codes

Code	Patient Type
AD*	Active Duty
MCA	MCP/Active Duty
MCD	MCP/Non-CHAMPUS Eligible
MCP	MCP/CHAMPUS Eligible CH *CHAMPUS
MED	Medicare
OTH*	Other
SUP*	Supplement Care

The system uses the following conditions and rules to derive the specific patient type for each eligible patient:

- All active-duty patients enrolled in MCP are designated as MCA. (You cannot change the patient type for active-duty patients.)

- All patients over the age of 64 are designated as MEDICARE (MED), provided they are not also CHAMPUS eligible. If they are CHAMPUS eligible, they can be enrolled in TRICARE Prime by changing the patient type to MCP/CHAMPUS eligible. Otherwise, they are assigned an ACV of “D” and enrolled in TRICARE Senior.

- All active-duty family members, retired family members, and retirees under the age of 65 are designated as MCP if they are CHAMPUS eligible. If they are not CHAMPUS eligible, they are space available only and may not enroll.

Press <Return> to accept this type, or enter MCP to enroll dual eligible patients in TRICARE or MCD.

2. MCP Enroll Date

   You can edit the field with a date in the past or future, but it may not overlap another enrollment period in DEERS.

   DEERS sends the ACV disenrollment dates in the eligibility transaction to prevent CHCS from creating a new enrollment episode that will overlap a prior episode.

   The MCP Enrollment Start date is determined differently for active-duty and non-active-duty beneficiaries and reciprocal disenrollments.

   Active-Duty - For active-duty beneficiaries, the Enrollment Start Date defaults to today's date. You can press <Return> to accept the default date or edit this date to any date using the following criteria:

   – Must be on or after October 1, 1992

   – Must be on or after the patient's date of birth

   – Must not overlap a previous enrollment episode in DEERS or CHCS.

   Non-Active-Duty - For non-active-duty beneficiaries, the Enrollment Start Date defaults to the first day of the next month (e.g., 1 May 2001). You may enter any first of the month date, past or future that meets the above three criteria.

3. Enter End Enroll Date.

   Active-Duty - If a date exists in the End Eligibility Date field for the active-duty beneficiary, this date is entered in the End Enroll Date field. The Enrollment End Date defaults to ‘Indefinite’ when the End Eligibility Date from DEERS is either all 9s or null in CHCS. You may press <Return> to accept this date or enter any date.

   For active-duty beneficiaries, the system updates the CHCS Enrollment End Date with the DEERS Eligibility End Date each time a DEERS eligibility transaction is performed in PAS/MCP. CHCS also updates the End Enrollment Date with the ending date on the last day of the month prior to the eligibility expiration date through a nightly batch job. Sites must review the MCP End of Eligibility Report regularly to catch active-duty that may be disenrolled prematurely. DEERS end eligibility dates are not always current.

Note: This process is automatic and does not require user interface.

Non-Active-Duty - The Enrollment End Date defaults to one year from the Enrollment Start Date, and is always on the last day of the given month (e.g., 30 April 2002). You can edit this date to be any end-of-month date as long as it is less than the system-defaulted Enrollment End Date and later than the Start Enroll Date.

5. Enrollment Comment

   Press <Return> to exit this field without making an entry, or enter an enrollment comment, using from 1 to 50 characters.

Complete the second MCP Enrollment screen

Refer to Figure 5-14. Second MCP Enrollment Screen, page 5-47.

As with the first screen, the fields in the top portion of the screen are filled in with data from the patient's previously entered MCP demographics information from CHCS. This information is for display only and cannot be edited.

The fields in the bottom portion of the screen can be edited.

```
PATIENT: PEARL,ZACHARY N                                          MCP ENROLLMENT


                Name: PEARL,ZACHARY N              FMP/SSN: 20/569-69-4415
    Patient Category: USN ACTIVE-DUTY                  DDS:
        Patient Type: AD/ACTIVE-DUTY                 Sex: MALE
          MCP Status:                              DOB/Age: 12 Jun 1975/26Y
 Primary Care Manager:                           PCM Phone:
         Primary OHI: NOT ASSIGNED               Case Mgmt: NO
                 ACV: A- TRICARE PRIME (ACTIVE-DUTY)
         Direct Care: ELIGIBLE                    Medicare: NOT ELIGIBLE
 ================================================================================

         Patient SSN: 569-69-4415

            Language:

      ID Card Number:                              Date Issued:
      Effective Date:                          Expiration Date:

Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 5-14. Second MCP Enrollment Screen

1. SSN

   The system automatically enters the SSN number in the SSN field from previously entered data. The cursor is positioned in the Language field.

2. Language

   Enter the primary language spoken by the patient if other than English. For a complete list of valid languages, enter a double question mark (??).

   Press <Return> to leave this field blank. The system automatically assumes that all patients can communicate in English.

These following fields default from the DEERS Eligibility information on a new enrollment only and are optional.

3. ID card number (optional)

4. Date Issued (optional)

   Enter the date of issue on the ID card.

5. Effective Date (optional)

   Enter the effective date of the ID card, or enter INDEFINITE.

6. Expiration Date (optional)

   Enter the expiration date of the ID card, or enter INDEFINITE.

7. File the data.

Select a PCM

The PCM Search Criteria screen displays. Refer to Figure 5-15. PCM Search Criteria Screen, page 5-49.

5.1.2 Assign a PCM

You must assign a PCM to a new enrollee to complete the enrollment process. If a PCM is not assigned, the enrollment for this patient is deleted. A PCM may be either an individual provider or a group provider. This option may be accessed on a new enrollment following the Enrollment screens or from the Demographic Display screen to change a PCM.

You enter this action from the Demographics Display screen action bar by selecting (P)CM on the action bar. The system then displays an action bar permitting you to change the search criteria for a PCM search, directly assign a user specified PCM, search for a PCM who meets search criteria, modify PCM history, print PCM data, view family PCM assignments, or quit this action and return to the Demographics Display screen action bar for continued processing in the Enrollment Enter/Edit options.

When you assign or reassign a PCM, that PCM's place of care is automatically entered as the Enrolling Division for the patient you are processing. If the selected PCM has multiple places of care for a particular agreement type, press <F9> to view each place of care to help you select the correct place of care for the patient you are enrolling.

Assign a PCM

- **Data Entry Process**

Access the PCM Search Criteria screen

Select the default PCM
or
Select a specific PCM

Search for a PCM:

– **Complete the PCM Search Criteria screen**
– **Complete the PCM Assignment screen**

Print Enrollment Form

Print patient address label

Exit at the Demographics Display screen

Access the PCM Search Criteria screen

```
                              PCM SEARCH CRITERIA
   Patient: PEARL,ZACHARY N                        FMP/SSN: 20/569-69-4415
  Language:                                            DDS:
 Specialty:                                        DOB/Age: 12 Jun 1975/26Y
       PCM:                                    PCM Gender:
  Location:                                          Date: 01 Nov 2001
------------------------------------------------------------------------------




------------------------------------------------------------------------------
Select (C)hange Search Criteria, (D)irect PCM Assignment,
       (V)iew Family Assignments, or (Q)uit PCM: C//
```

Figure 5-15. PCM Search Criteria Screen

The PCM Search Criteria screen action bar contains the following actions:

- **(C)hange Search Criteria -** Displays five search criteria: specialty, location, PCM gender, patient language, and default search criteria. You select the criteria you need. The system prompts you to enter values for each of the criteria that you have selected. The system then returns to the PCM Search Criteria action bar.

- **(D)irect PCM Assignment -** Enter the name of a specific PCM.

- **(S)earch PCM -** Use this action only if search criteria have been set using the action described in the "Change Search Criteria" section above. All PCMs who meet the selection criteria display and prompt you to select one. (Using <F9>, you can view location (place of care) data and assignment preferences, for a particular PCM prior to assigning the PCM to the patient.) If you are changing the patient's PCM, the system prompts you to enter the change assignment reason. The system then prompts you to indicate whether to print the PCM report. The system then returns to the PCM Search Criteria action bar.

- **(M)odify PCM History -** Use this action only if the patient has formerly had a PCM different from the current one. An action bar prompts you to modify data for a PCM, view data of past and present PCMs, or quit this action and return to the PCM Search Criteria action bar.

- **Modify PCM History, Modify -** Displays the list of all PCMs who were formerly assigned to the patient. The system prompts you to select the PCM whose data is to be modified. You are prompted to modify the date of change and the date the PCM was de-assigned from the patient. You are prompted to enter the change assignment reason and returns to the PCM Search Criteria action bar.

- **Modify PCM History, View -** Displays the list of all PCMs who were formerly assigned to the patient. Press <Return> to return to the PCM Search Criteria action bar.

- **(P)rint PCM -** Displays or prints the PCM report, containing a listing of data pertaining to the current PCM as specified by you, then returns to the PCM Search Criteria action bar.

- **(V)iew Family Assignments -** Displays a list of all the family members and the PCMs (if any) assigned to them. Press <Return> to return to the PCM Search Criteria action bar.

- **(Q)uit PCM -** Returns you to the Demographics Display screen action bar.

The PCM Search Criteria screen has three windows:

The top Display Window displays the following active search parameters:

- Patient Name (left side of window)
- Language - Languages other than English
- Specialty - PCM's specialty
- PCM - Provider name
- Location - ZIP codes or location name
- FMP/SSN - Patient FMP/SSN
- DDS - DEERS Dependent suffix for patient
- DOB/Age - Patient's DOB and age
- PCM Gender - Patient preference for gender of PCM
- Date - Date PCM assigned.

The middle Select Window displays PCM picklists. At this point, the Select window is blank.

The bottom Interact Window displays messages, prompts, and action bars.

An action bar displays a list of options. Select a character(s) within parentheses for the desired option, then press <Return>. The selected function is performed and the action bar redisplays. The action bar is not case-sensitive.

Default values appear at the end of the action bar prompt followed by a double slash (//). Press <Return> to select the default. If no default is present, make a selection or press <Q> or <^> then press <Return> to quit this action bar`.

Select the default PCM

1. Accept the default PCM displayed.

2. File the PCM.

3. Display/Print PCM and place of care? NO//

   Enter YES to display or print the PCM place of care information.

   To accept the default not to display or print the PCM place of care, press <Return>. You return to the PCM Search Criteria screen.

4. Select Device.

   Press <Return> to print to the screen.

5. Enter Right Margin.

   The screen displays the provider's address, phone number, directions to the place of care, hours of service, and any additional comments.

6. Press <Return><Return> to continue (to return to the PCM Search Criteria screen).

Select a specific PCM

1. All the records pertaining to the chosen PCM display and you are prompted to select one.

2. Using <F9>, you can view location data and assignment preferences for the PCM before assigning the PCM to the patient.

3. If you are changing the patient's PCM, the system prompts you to enter the change assignment reason.

4. The system prompts you to indicate whether to print the PCM report.

5. The system then returns to the PCM Search Criteria action bar.

> **Note:** A default PCM may display at the *Select PCM* prompt. This displays only for active-duty. Whenever an active-duty patient with that UIC is enrolled and a Direct PCM assignment is performed, the default PCM displays. This default PCM has been entered previously in the MCP files. A specific UIC was assigned a specific default PCM.

6. You may accept the default PCM, or enter a new PCM name.

7. Select the Quit action (to quit the PCM Search Criteria screen).

   The enrollment transaction is batched for later transmission to DEERS.

Search for a PCM

Press <Return> to accept the Change Search Criteria default.

The PCM Search Criteria screen redisplays. Refer to Figure 5-16. PCM Search Criteria (Change Search Criteria), page 5-53. The search parameters are listed in the middle Select Window.

```
                              PCM SEARCH CRITERIA
                Patient: PEARL,ZACHARY N                  FMP/SSN: 20/569-69-
4415
               Language:                                      DDS:
              Specialty:                                  DOB/Age: 12 Jun
1975/26Y
                   PCM:                                PCM Gender:
               Location:                                     Date: 01 Nov 2001
--------------------------------------------------------------------------------
-
              Specialty:
               Location:
             PCM Gender:
       Patient Language:
Default Search Criteria:


---------------------Specialty and Location are required-----------------------
-
Use SELECT key to select SEARCH CRITERIA to be changed.
```

Figure 5-16. PCM Search Criteria (Change Search Criteria)

Complete the PCM Search Criteria screen

1. Specialty

   A specialty and location are required.

   Position the cursor next to the desired search criteria and press <Select>.

   The specialty you enter is used when searching for a PCM.

   The specialty you enter displays in the top Display Window.

2. Confirm the specialty selected.

   You can deselect a category by pressing <Select> again.

   When all selections have been marked, activate the selections by pressing <Return>.

Selecting the Default Search Criteria parameter commands the system to automatically use the currently selected search criteria parameters for your user ID during each subsequent search action until you change them, even if you log off the system.

The prompt to enter the specialty displays in the bottom Interact Window. Enter a double question mark (??) at the specialty prompts to display a picklist of specialties and specialty combinations.

3. Location

This search criteria specifies the location by ZIP code(s) to search for a PCM.

The prompt accepts three possible formats:

ZIP Code(s) - Enter one to five-digit ZIP codes or enter partial ZIP codes for 5-digit ZIP codes. Nine-digit ZIP codes are not allowed. If you enter more than one ZIP code, separate each ZIP code by a comma.

EXAMPLES:

Select Location: 23707

Select Location: 23707,23708,23665

If you enter more than one ZIP code, the *This ZIP Code Combination does not currently exist. Do you wish to generate cross-references for this ZIP Code Combination? No//* message and prompt might display if that combination has never been entered before.

If you enter NO at this prompt, the system does not generate cross-references for the combination of ZIP codes you entered. Providers display in ZIP code order. Within each ZIP code, each provider is sorted from highest to lowest discount rate. Providers are randomized within each discount rate.

If you enter YES at this prompt, the system generates cross-references for the combination of ZIP codes entered. Providers display from highest to lowest discount rate, regardless of the ZIP code.

You should accept the default of YES, unless otherwise instructed by your site policy and procedures. If you enter YES, the system is more efficient when this combination is used again. Providers are randomized within each discount rate.

Wild Card(s) - Enter from one to five wild cards. A wild card is represented by the first three or four characters of a ZIP code. It allows you to search a range of ZIP codes. If you enter more than one wild card, separate each wild card by a comma.

EXAMPLES:

Select Location: 237

The system searches the range of ZIP codes from 23700 to 23799.

Select Location: 2370

The system searches the range of ZIP codes from 23700 to 23709.

Select Location: 2370,236,2355

The system searches the range of ZIP codes including 23700 to 23709, 23600 to 23699, and 23550 to 23559.

Providers display according to ZIP codes. Within each ZIP code, the providers are sorted from highest to lowest discount rate.

ZIP Code Combination - Enter one ZIP code combination. This is a text identifier (defined by the site) representing a range of ZIP codes. ZIP code combinations that cross over TRICARE regional service areas may still be within the same catchment area.

EXAMPLES:

Select Location: NEW YORK CATCHMENT AREA

Select Location: NEW YORK CITY

Select Location: MANHATTAN

To display existing ZIP code combinations, enter a double question mark (??).

If you enter a ZIP code combination that does not currently exist, the *This ZIP Code Combination does not currently exist. Do you wish to generate Cross References for this ZIP Code Combination now? No//* message and prompt displays.

Create a Cross Reference?

Creating a cross-reference helps the system become more efficient for later searches using this same ZIP code combination.

4. PCM Gender

   Enter the PCM's gender. If this is selected as part of the search criteria, only PCMs of the specified gender display on the PCM Assignment screen.

5. Patient Language

   If this is selected as part of the search criteria, each PCM who speaks the patient's preferred language is indicated by a tilde (~) next to the name.

6. Confirm the language entry.

   If this is selected as part of the search criteria, each PCM who speaks the patient's preferred language is indicated by a tilde (~) next to the name.

7. Default Search Criteria

   If this is selected, the *Do you want the current criteria selections to be saved as your Default Selection Criteria? YES//* prompt displays. If you accept the YES default, the selected search criteria remain selected for all beneficiaries until it is deselected for your user ID.

   After all the selected search criteria have been entered, the PCM Search Criteria screen redisplays. The Search PCM action has been added to the PCM action bar.

Note: In CHCS Version 4.5, active-duty beneficiaries could not be assigned a PCM with NET or SUP agreements. In CHCS Version 4.6, MCP enrollment clerks/supervisors who hold the CPZ PCM AGR LOCK security key can assign active-duty beneficiaries to network PCMs with the agreement types NET and SUP.

Complete the PCM Assignment screen

The middle Select Window of the PCM Assignment screen displays a list of the PCMs who meet the search criteria specified. A PCM may appear on this list multiple times, once for each place of care and specialty and agreement combination. The list of PCMs display in random order to avoid preferential provider choices. For example, the PCMs

do not display in alphabetical order. Refer to Figure 5-17. PCM Assignment Screen, page 5-57.

```
                                PCM ASSIGNMENT
   Patient: PEARL,ZACHARY N                          FMP/SSN: 20/569-69-4415
  Language: SPANISH                                    DDS:
 Specialty: FAMILY PRACTICE/PRIMARY CARE             DOB/Age: 12 Jun 1975/26Y
       PCM:                                       PCM Gender:
  Location: 20307,20817                               Date: 01 Nov 2001
-------------------------------------------------------------------------------
-
   Provider                CS Cat   Specialty        Agr Locat Sex Disc   Avail
-------------------------------------------------------------------------------
-
    ALBERT,CHARLES D       B   MD   FAMILY PRACTICE  MTF 20307   M  MTF     468
    ALTON,PATRICIA M       E   MD   FAMILY PRACTICE  MTF 20307   F  MTF     500
    AUSTIN, GILBERT, M     E   MD   FAMILY PRACTICE  MTF 20307   M  MTF     485

Use SELECT key to select PCM to be assigned.
Press F9 key to view Assignment Preferences, Place of Care or Watch Codes
```

Figure 5-17. PCM Assignment Screen

For each provider, the list also displays the following information:

Certification Specialty (CS) - The level of Board Certification the provider holds for this specialty. Valid codes are:

Blank	Not Certified, or Does Not Exist in the Specialty File
E	Board Eligible
BO	Board Certified
NA	National Certification.

Provider Category (CAT) - The professional level of the provider; e.g., MD=Physician, NP=Nurse, PA=Physician Assistant.

Agreement Type (Agr) - The following are valid agreement types:

CON	Contract
MTF	MTF Staff
NET	Civilian Network Provider
NON	Non-Network/Exception
PEX	Partner External
PIC	Partner Internal
SUP	Supplemental Care/Diagnostic Services.

Location (Locat) - ZIP code of the provider's place of care.

Provider Gender (Sex) - The valid specifications for provider gender are:

M	Male
F	Female
Blank	None specified.

Overall Discount Rate (Disc) - The valid overall discount rates are:

CA - Group accepts the CHAMPUS allowable rate for services rendered.

CA-x% - Group accepts the CHAMPUS allowable rate minus an established percentage for services rendered.

MTF - Group members are military providers with no direct charge for services rendered to eligible beneficiaries.

UC - Group accepts the usual and customary rate for services rendered.

UC-x% - Group accepts the usual and customary rate minus an established percentage for services rendered.

Total Available PCM Capacity (Avail) - The total available patient capacity for the provider. The system ensures that each PCM has a capacity of at least 1 before listing them on the screen.

> **Note:** The tilde (~) next to a provider's name indicates that the provider speaks the preferred language of the patient.

MTF providers display first, followed by providers based on their overall discount rate (providers with the largest discount first). Civilian providers are listed in random order each time a new list displays.

The Other Health Insurance screen displays only for non-active-duty patients. *Do you want to print enrollment form? No//* displays.

Print Enrollment Form

Enter “Yes” to print the enrollment form.

Refer to Figure 6-78. Managed Care Enrollment Form.

Print patient address label

Enter "Yes" to print a single mailing label for the patient.

The Demographics Display screen displays

Exit at the Demographics Display screen

1. Press Quit to exit the Demographics Display screen and return to the Enrollment Processing Menu

5.1.3 Enroll Family Members

Menu Path: PAS System Menu → M → EMCP → EENR

Enroll Family Members

- **Data Entry Process**

Select patient

Complete the Patient - Initial Information screen

Complete the Family Member screen

Select family members for enrollment processing

Confirm family members for enrollment

Complete the Mini-Registration screen

Enroll the family members

– **Complete the MCP Enrollment screens**

Assign a PCM:

– **Complete the PCM Search Criteria screen**

- **Select the (S)earch PCM action**
- **Expand the provider record**
- **Select (P)lace of Care**

Select patient

1. Enter the patient identifier.

   For this example, the patient is not registered at your facility and you must perform a Mini Registration for the patient.

   The prompt, Are you adding [patient name]' as a new PATIENT (the nth)? displays.

2. Confirm that you are adding a new patient.

3. Enter Sponsor Name.

4. Confirm the Sponsor Name.

   The Patient - Initial Information screen displays. Refer to Figure 5-18. Patient - Initial Information Screen, page 5-60. The Sponsor Name, Sponsor SSN, and Patient Name fields are automatically entered. You cannot edit data in these three fields.

Complete the Patient - Initial Information screen

```
Sponsor Name: PEARL,ZACHARY N                      Patient - Initial
Information
 Sponsor SSN: 569-69-4415



               Patient Name: PEARL,ZELDA N
                        FMP:
                        DOB:
                        SSN:
                     PATCAT:


 Help = HELP      Exit = F10     File/Exit = DO                    INSERT OFF
```

Figure 5-18. Patient - Initial Information Screen

1. FMP

   The FMP for the sponsor is 20. The FMP is used to signify the relationship between the sponsor and the patient.

   If the sponsor and the patient are the same, the cursor displays in the Sponsor FMP field, and you must enter 20 as the sponsor FMP.

   If the sponsor is not the same as the patient, the FMP is blank. You must enter the patient's FMP.

2. DOB

   Enter the DOB. Check the DEERS Eligibility Data screen for the DOB to ensure the correct date. If the correct DOB is not available, you may choose not to enroll the patient until the correct DOB is known. DEERS does not enroll the patient if the CHCS DOB does not match the DEERS DOB. Usually these patients are not enrolled until they correct their DOB in DEERS.

3. SSN

   Enter the nine-digit patient SSN for this patient in the format nnn-nn-nnnn. (You need not enter the dashes.)

4. Verify SSN.

   As soon as the SSN entry is completed, the system deletes the SSN from view and asks you to verify the patient's SSN entry.

   Entering the patient's SSN twice is a system device to reduce duplicate patient entries.

   The two SSN entries must match before the system allows you to continue with the registration.

   If the two SSN entries do not match, you must reenter the SSN.

5. PATCAT

   The PATCAT indicates the patient's service affiliation and entitlement.

   If the patient category is unknown, enter a double question mark (??) to display a list of valid patient category codes. For enrollment, only patient categories ending

in 11 (active-duty), 31 (retired), 41 (active-duty family member), or 43 (retiree family member) are valid, because CHCS calculates ACV values based on PATCAT. CHCS determines the patient ACV, not DEERS. DEERS rejects the enrollment if the ACV is inconsistent with the patient's beneficiary category on DEERS so it is important to correct the patient category in CHCS if inconsistent with the DEERS patient status.

6. File the data.

   A DEERS Eligibility check is performed.

   The Family Member screen displays with all family members listed. Refer to Figure 5-19. Family Member Screen, page 5-62.

Complete the Family Member screen

```
                              FAMILY MEMBER SCREEN
    Patient Name: PEARL,ZELDA N                          FMP/SSN: 30/569-69-
4415
             DOB: 02 Jan 1976
    Sponsor Name: PEARL,ZACHARY N                  Sponsor SSN: 569-69-4415
 Elig Start Date: 25 Sep 1997                    Elig End Date: 2000
-------------------------------------------------------------------------------
--
 Name                Sex   DOB          DDS  ACV  Dir  Med  DMIS ID
_______________________________________________________________________________
__

 PEARL,ZACHARY N     M     12 Jun 1975  20    N    E    N
 PEARL,ZELDA N       F     02 Jan 1976  30    C    E    N




PEARL,ZELDA N is this the patient you are enrolling? Yes//
```

Figure 5-19. Family Member Screen

1. Upon entering the DEERS Check (Enrollment/Family Member screen) action, the system first displays the name of the patient that it has identified and will request confirmation prior to continuing with the DEERS check functionality in this action. You will be allowed either to confirm and continue or to enter a negative response and return to the *Select PATIENT NAME* prompt to specify another patient name.

2. If the patient is ineligible for this enrollment, the system then allows you to enter an override code and continue with the enrollment or to abort the enrollment and return to the *Select PATIENT NAME* prompt. Please note that though CHCS will permit a user to collect and store enrollment information for an ineligible beneficiary, DEERS will reject the enrollment and it becomes invalid in CHCS. The beneficiary data must be corrected in DEERS in order for the beneficiary to be enrolled.

3. If the patient is eligible for enrollment or has had an override reason stipulated, the system allows you to process other family members from the displayed list. The system then processes each family member selected as it did the first family member. For example, registration data will be input on the Mini Registration screen for each family member to be enrolled, then the user may select and enroll those family members from the family member list.

   F9 View of family members – Position the cursor next to the family member name and press <F9> prior to enrolling a family member to view which family members are currently registered in CHCS.

Select family members for enrollment processing

Confirm family members for enrollment

The DEERS Eligibility screen displays. Refer to Figure 4-10. Current DEERS Eligibility.

1. Select the (C)ontinue action on the DEERS Eligibility screen.

If a Mini Registration (new or an edit) is performed for a patient who already has one or more family members registered in CHCS, the system allows you to copy demographic information such as addresses and telephone numbers. Use caution when copying demographic information from the sponsor to the family member. If the sponsor is remotely located, the family member's address will be incorrect. It is recommended that family member information be copied from another family member or entered independently.

Refer to Figure 5-20. Family Member Demographics Move Screen, page 5-64.

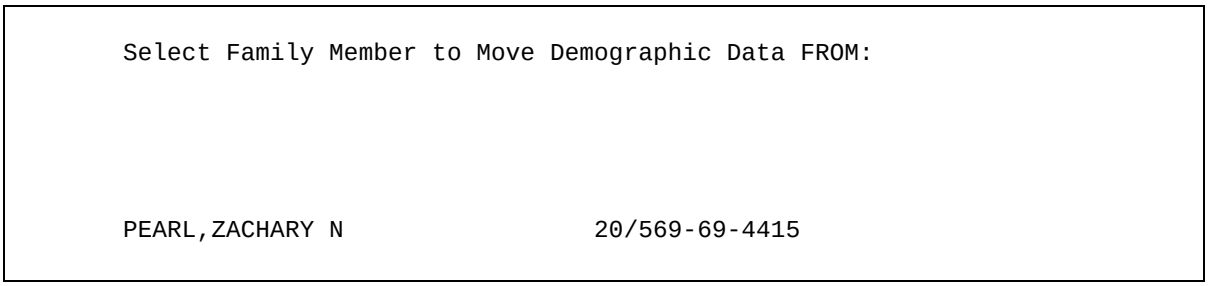


Figure 5-20. Family Member Demographics Move Screen

The *Select Family Member to Move Demographic Data From* prompt displays along with a selection list of registered family members.

2. Select the family member whose demographic data you want to copy.
3. Use the down-arrow key to position the cursor next to the desired family member. When the cursor is positioned, press <Select>.

   An asterisk (*) appears next to the selected family member.
4. You can deselect a family member by pressing <Select> again.
5. Press <Return> to activate the selection.

Complete the Mini Registration screen

Refer to Figure 5-21. Mini Registration Screen, page 5-65.

```
Patient: PEARL,ZELDA N                                          Mini
Registration
FMP/SSN: 30/569-69-4415       DOB: 02Jan76       PATCAT: N41    Sex: F
                 Personal Data - Privacy Act of 1974 (PL 93-579)
      Patient: PEARL,ZELDA N                          DOB: 02 Jan 1976
       PATCAT: N41 (USN FAM MBR AD)                   FMP: 30
   Home Phone: 974-2333        W:                     SSN: 100-20-0068
 Patient Addr: 1020 NEWPORT DRIVE                    Sex: FEMALE
         City: HAMPTON              St/Cntry: VA     Zip: 23665

      Sponsor: PEARL,ZACHARY N                   Service: NAVY
          FMP: 20                          Sponsor SSN: 569-69-4415
       PATCAT: N11 (USN ACTIVE-DUTY)                  DOB: 12 Jun 1975
  Command Sec: PERSONNEL RELIABILITY PROGRAM         Rank: CHIEF PETTY OFFICER
 Station/Unit: WALTER REED MED HOLD PP
 Duty Address: 3939 CONSTITUTION AVE
         City: WASHINGTON           St/Cntry: DC     Zip: 20307
   Duty Phone:                                       DSN: 331

  O/P Rec Loc:
  O/S Rec Loc:
  Primary Phy:
  Reg Comment:
 Help = HELP      Exit = F10     File/Exit = DO                    INSERT OFF
```

Figure 5-21. Mini Registration Screen

Refer to Section 5.1.1 Enroll a Patient, page 5-6, for an explanation of the Mini Registration fields.

The Demographics Display screen displays.

Enroll the family members

1. Select the (E)nrollment action on the Demographics Display screen.

Complete the MCP Enrollment screens

Refer to Figure 5-22. MCP Enrollment - Continuation Screen, page 5-66.

```
ENROLLMENT HISTORY: 01 Jul 2001                  MCP Enrollment -- CONTINUATION


                Name: PEARL,ZELDA N                      FMP/SSN: 30/569-69-
4415
     Patient Category: USN FAM MBR AD                        DDS:
         Patient Type: MCP/CHAMPUS ELIGIBLE                  Sex: FEMALE
           MCP Status:                                   DOB/Age: 02 Jan
1976/25Y
 Primary Care Manager:                                 PCM Phone:
          Primary OHI: NOT ASSIGNED                    Case Mgmt: NO
                  ACV: E-TRICARE PRIME (CHAMPUS)       Direct Care:
   Enrolling Division:                                  Medicare:
 ================================================================================

         Patient Type: MCP/CHAMPUS ELIGIBLE

      MCP Enroll Date: 01 Nov 2001
      End Enroll Date: 30 Jun 2004

   Enrollment Comment:


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 5-22. MCP Enrollment - Continuation Screen

Refer to Section 5.1.1 Enroll a Patient, page 5-6, for an explanation of the MCP Enrollment - Continuation screen fields.

Refer to Figure 5-23. Second MCP Enrollment Screen, page 5-67.

```
PATIENT: PEARL,ZELDA N                                          MCP ENROLLMENT


                Name: PEARL,ZELDA N                 FMP/SSN: 30/569-69-4415
    Patient Category: USN FAM MBR AD                    DDS:
        Patient Type: MCP/CHAMPUS ELIGIBLE              Sex: FEMALE
          MCP Status:                                DOB/Age: 02 Jan 1976/25Y
 Primary Care Manager:                            PCM Phone:
         Primary OHI: NOT ASSIGNED                Case Mgmt: NO
                 ACV: E-TRICARE PRIME (CHAMPUS)
         Direct Care:                              Medicare:
 ================================================================================

         Patient SSN: 100-20-0068

            Language: SPANISH

       ID Card Number: 19945                    Date Issued: 01 Jan 2001
       Effective Date: 01 Jan 2001          Expiration Date: 17 Nov 2004



File/exit    Abort    Edit
File changes and exit.
```

Figure 5-23. Second MCP Enrollment Screen

Assign a PCM

Refer to Figure 5-24. PCM Search Criteria (Change Search Criteria), page 5-67. Refer to Section 5.1.2 Assign a PCM, page 5-48, for an explanation of how to assign a PCM.

```
                              PCM SEARCH CRITERIA
   Patient: PEARL,ZELDA N                           FMP/SSN: 30/569-69-4415
  Language:                                            DDS:
 Specialty:                                        DOB/Age: 02 Jan 1976/25Y
       PCM:                                     PCM Gender:
  Location:                                           Date: 21 Jun 2001
--------------------------------------------------------------------------------
-
   Specialty
   Location
   PCM Gender
   Patient Language
   Default Search Criteria
--------------------Specialty and Location are required-----------------------
Use SELECT key to select SEARCH CRITERIA to be changed.
```

Figure 5-24. PCM Search Criteria (Change Search Criteria)

Complete the PCM Search Criteria screen

Refer to Figure 5-15. PCM Search Criteria Screen, page 5-49.

Select the (S)earch PCM action

Refer to Figure 5-15. PCM Search Criteria Screen, page 5-49.

Expand the provider record

1. View expanded data for the provider: [provider name] then <F9>.

   Place the cursor next to the provider record you wish to view, then press <F9>. The PCM Assignment screen displays for the selected provider . Refer to Figure 5-25. PCM Direct Assignment Screen (Expanded Provider Record), page 5-68.

```
                              PCM DIRECT ASSIGNMENT
   Patient: PEARL,ZELDA N                          FMP/SSN: 30/569-69-4415
  Language: SPANISH                                    DDS:
 Specialty: FAMILY PRACTICE/PRIMARY CARE           DOB/Age: 02 Jan 1976/25Y
       PCM:                                     PCM Gender:
  Location:                                          Date: 21 Jun 2001
-------------------------------------------------------------------------------
-
   Provider                CS Cat   Specialty        Agr Locat Sex Disc   Avail

   ~AUSTIN,GILBERT M       E  MD    FAMILY PRACTICE  MTF 20307  M  MTF      485



Select (A)ssignment Preferences, (P)lace of Care, or (Q)uit: P//
```

Figure 5-25. PCM Direct Assignment Screen (Expanded Provider Record)

Select (P)lace of Care

1. Enter P to display provider place of care information.

2. The PCM Assignment screen displays showing the provider's address and directions to the place of care . Refer to Figure 5-26. PCM Direct Assignment Screen (Place of Care), page 5-69.

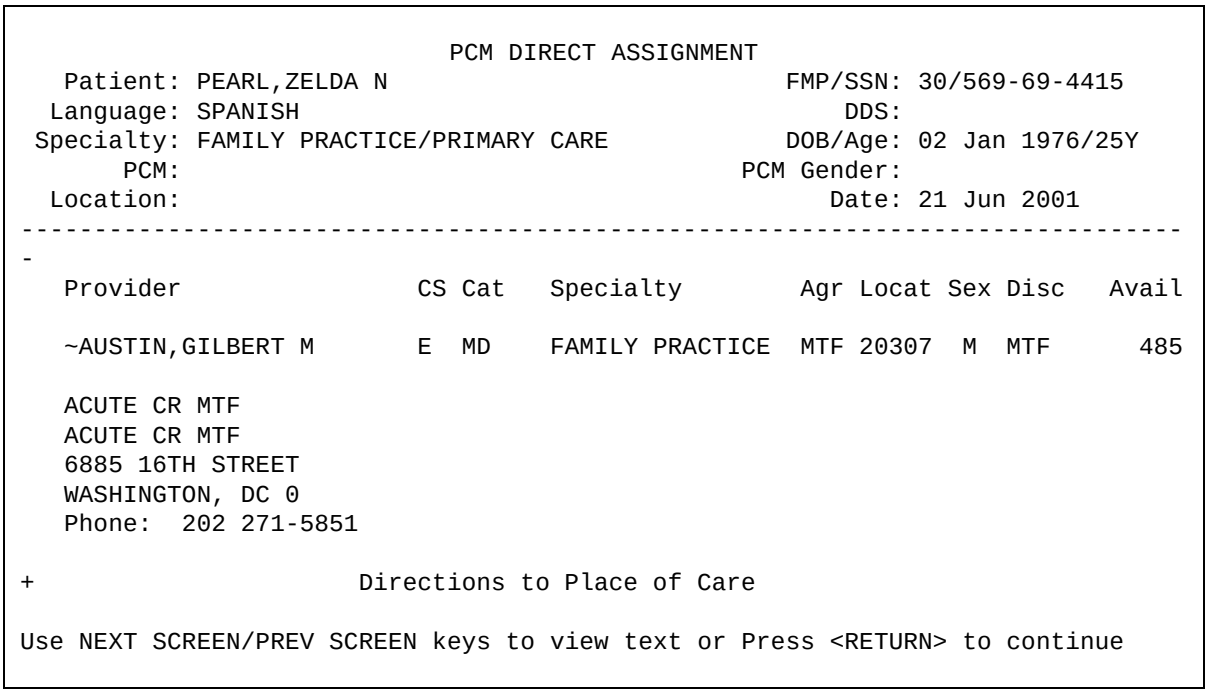


Figure 5-26. PCM Direct Assignment Screen (Place of Care)

1. Press <Return> to view the hours of service.

2. Quit and exit the PCM Assignment screens.

   The PCM Assignment screen displays again.

The enrollment transaction is sent to DEERS after the PCM has been assigned to the new patient.

5.1.4 Enter OHI Information

The Standard Insurance Company Table - The DOD has developed a standard insurance company table to be used in CHCS. Each site stores a subset of this file locally in the Insurance Company file to support third party collections. Security for the Insurance Company file is controlled through FileMan access codes and there is an audit trail of changes made to this file.

The purpose of this table is to ensure consistent identification of insurance data, minimize data entry requirements, and minimize duplicate company identification. To accomplish these goals, the patient health insurance data input screens have been modified to provide uniform collection of data across subsystems (because data elements are required from PAS/MCP, PAD and Medical Services Accounting (MSA)/Third Party

Collection (TPC), the input screens contain all requirements and are identical for all functionalities).

When you update OHI policy data for a registered outpatient who qualifies for TPC billing, the system automatically performs CHCS table lookups.

You may optionally enter an unlimited number of OHI policies for any patient who is non-active-duty.

If no OHI policies exist for this patient, the message - *No Policies Found* - displays in the middle Select Window.

- **Data Entry Process**

Access the Other Health Insurance - Enter/Edit screen

Select the (A)dd OHI action

Complete the Other Health Insurance Enter/Edit screen

Complete the second Other Health Insurance screen

Access the Other Health Insurance - Enter/Edit screen

The first Other Health Insurance - Enter/Edit - screen is divided into two parts. The top half displays the patient demographic data entered from previous screens. Refer to Figure 5-27. Other Health Insurance Screen, page 5-71. The bottom half displays fields to be edited with OHI information. Refer to Figure 5-28. Other Health Insurance - Enter/Edit Screen, page 5-72.

```
                              OTHER HEALTH INSURANCE

         Patient: PEARL,ZELDA N                          FMP/SSN: 30/569-69-4415
Patient Category: USN FAM MBR AD                             DDS: NOT ENTERED
MCP Patient Type: MCP/CHAMPUS ELIGIBLE                       Sex: FEMALE
      MCP Status: PENDING ENROLLMENT                      DOB/Age: 02 Jan 1976/25Y
             PCM: FAM MED MTF                               Date: 01 Nov 2001
--------------------------------------------------------------------------------
-
     Insurance Co Name    Eff Date   Policy Holder            Billing Status
       Policy Number      Exp Date     Relationship
--------------------------------------------------------------------------------
-




---------------------------------No Policies Found-----------------------------
-
Select (A)dd OHI, (I)nsurance Company Enter/Edit, (V)iew Expired Policies Also,
       or (Q)uit OHI: Q//
```

Figure 5-27. Other Health Insurance Screen

Select the (A)dd OHI action

The following actions display on the action bar:

- **(A)dd OHI -** Enters a new OHI policy from the standard insurance table listing. The number of possible entries is unlimited.
- **(E)dit -** Edits an existing OHI policy.

> **Note:** This action only displays if OHI information has already been entered.

- **(I)nsurance Company Enter/Edit -** Enters or edits insurance company information.
- **(V)iew Expired Policies Also -** Displays information for expired insurance policies, in addition to active policies that the patient holds.
- **(C)opy OHI -** Copies existing OHI information from other family members to the specified patient.

> **Note:** This action displays only if the patient is non-active-duty, is currently registered in CHCS, and other family members have existing insurance policies.

– **(Q)uit -** Allows you to exit the Other Health Insurance screen.

Complete the Other Health Insurance - Enter/Edit screen

```
POLICY:              {}                  OTHER HEALTH INSURANCE - ENTER/EDIT

                Patient: PEARL,ZELDA N                FMP/SSN: 30/569-69-4415
       Patient Category: USN FAM MBR AD                   DDS:
       MCP Patient Type: MCP/CHAMPUS ELIGIBLE             Sex: FEMALE
             MCP Status: PENDING ENROLLMENT           DOB/Age: 02 Jan 1976/25Y
                    PCM: FAM MED MTF                     Date: 01 Nov 2001
================================================================================
          Policy number:
 Insurance Company Name:                                 Phone:
         Effective Date:                      Expiration Date:



         Primary Policy:
            Policy Type:                       Billing Status:
             Group Name:                         Group Number:

    Precertification/UR:


   PreCert/UR on Report:        PreCert/UR Authorization Code:

Help = HELP      Exit = F10     File/Exit = DO                       INSERT OFF
```

Figure 5-28. Other Health Insurance - Enter/Edit Screen

1. Policy Number

   Enter this patient's insurance policy number using from 3 to 17 characters.

2. Insurance Company Name

   Enter the name of the patient's insurance company from the standard table.

3. Confirm the Insurance Company Name.

4. Phone

   The Phone field is defaulted from the information maintained in the system OHI file for this insurance company. The cursor automatically moves to the Effective Date field.

5. Effective Date

   Press <Return> to accept the default of today's date or enter another date.

6. Expiration Date

7. Policy Type

   Enter the appropriate policy type for this patient's selected insurance. Refer to Table 5-3. Other Health Insurance Policy Types, page 5-73, for the policy types that can be entered in this field.

Table 5-3. Other Health Insurance Policy Types

Code	Policy Type
CS	CHAMPUS Supplement
CH	CHAMPUS/CHAMPVA
CO	Commercial
GR	Employer Group
MS	MEDICARE/MEDICAID Supplement
SD	Student

8. Billing Status

   Accept the default of Billable.

   Policies may be billable (inpatient and outpatient, inpatient only, or outpatient only) or non-billable.

   The Primary Policy must be billable. All secondary policies can be either Billable or Non-billable. The billing status does not change after the policy has expired.

9. Group Name and Group Number

   If the patient is covered under a group policy, enter the insured group name and the Group Number. These are free-text fields.

For this example, the policy is not a group policy.

10. Precertification/UR

    Enter an optional Precertification and Utilization Requirement (UR) free-text comment.

    Medical conditions, restrictions, or requirements imposed by the insurance company on this policy should be entered in this field. Examples of information that would be entered include: “Pre-admission approval is required,” or “Second opinion authorized.”

11. PreCert/UR on Report

    The Precertification and Utilization Requirement on Report field has a Yes or No choice. If you select Yes, the text entered in the Precertification and Utilization Requirement field displays on the Insurance Precertification/Utilization Requirement Roster (URR) report.

12. Enter PreCert/UR Authorization Code.

    The Precertification and Utilization Requirement Authorization Code is a free text field containing the authorization code received from the insurance company which verifies that the insurance company authorized the procedure.

    This screen collects policy holder and employer data for the policy.

Complete the second Other Health Insurance screen

Refer to Figure 5-29. Second Other Health Insurance - Enter/Edit Screen, page 5-75.

```
POLICY: AETNAFL       {3377}              OTHER HEALTH INSURANCE - ENTER/EDIT

                Patient: PEARL,ZELDA N                FMP/SSN: 30/569-69-4415
       Patient Category: USN FAM MBR AD                   DDS:
       MCP Patient Type: MCP/CHAMPUS ELIGIBLE             Sex: FEMALE
             MCP Status: PENDING ENROLLMENT           DOB/Age: 02 Jan 1976/25Y
                    PCM: FAM MED MTF                    Date: 21 Jun 2001
================================================================================
     Policy Holder Name:
      Policy Holder SSN:
Relationship to Insured:
         Street Address:
                   City:
                  State:
                    Zip:

  Insured Employer Name:                                Phone:
        Street Address:
                   City:
                  State:
                    Zip:

Help = HELP      Exit = F10     File/Exit = DO                      INSERT OFF
```

Figure 5-29. Second Other Health Insurance - Enter/Edit Screen

1. Policy Holder Name

2. Confirm the Policy Holder.

3. Policy Holder SSN

   The policy holder's SSN displays if the policy holder is registered in CHCS. Press <Return> to accept the SSN of the policy holder. If the policy holder is not registered in CHCS, enter the policy holder SSN.

4. Relationship to Insured

   Enter the relationship of this patient to the policy holder. To list valid relationships, enter a double question mark (??). If the address is defaulted, you may press <Return> to bypass the defaulted field.

5. Insured Employer Name

   If this is a group insurance policy maintained by an insured employer, enter the name of the employer. The cursor moves to the Phone field. If this is not a group insurance policy for an employer, press <Return> to exit this field without an entry. You are prompted to file the data.

6. Enter the address or press <Return> to bypass the remaining fields.

7. File the data.

The Other Health Insurance screen displays with policies listed. Refer to Figure 5-30. Completed Other Health Insurance Screen, page 5-76. Note that a new action, (E)dit OHI, has been added to the action bar. You may now enter another insurance company name or edit the existing insurance policy information.

```
                              OTHER HEALTH INSURANCE

         Patient: PEARL,ZELDA N                          FMP/SSN: 30/569-69-4415
Patient Category: USN FAM MBR AD                             DDS: NOT ENTERED
MCP Patient Type: MCP/CHAMPUS ELIGIBLE                       Sex: FEMALE
      MCP Status: PENDING ENROLLMENT                      DOB/Age: 02 Jan 1976/25Y
             PCM: FAM MED MTF                               Date: 21 Jun 2001
------------------------------------------------------------------------------
-
     Insurance Co Name    Eff Date   Policy Holder            Billing Status
       Policy Number      Exp Date     Relationship

  P) AETNA LIFE AND CASU  21 Jun 01  PEARL,ZELDA N            BOTH
       3377               01 Jun 02    SELF



Select (A)dd OHI, (E)dit OHI, (I)nsurance Company Enter/Edit,
       (V)iew Expired Policies Also, or (Q)uit OHI: Q//
Do you want to print enrollment form? No//
```

Figure 5-30. Completed Other Health Insurance Screen

5.1.5 Enroll Family Members Into the MCP Using the Family Action

Menu Path: PAS System Menu → M → EMCP → EENR

Family Enrollment – Use this action only if the patient is already registered. An action bar prompts you to enroll all family members, enroll selected individual family members, or quit the family enrollment action and return to the Demographics Display action bar.

Family Enrollment - All Family Members –A list displays all family members. All nonenrolled family members are marked as selected, and the system prompts you to deselect those family members who are not to be enrolled. The system then prompts you to enroll each selected family member. For each family member, you are asked whether to copy the patient's OHI data to the family members.

For each family member, the system prompts you for the following: you must indicate whether or not to copy the patient's OHI data to the current family member. If so, you must indicate the relationship of the current family member to the insured, who is not necessarily the same as the patient. Additionally, you need to indicate whether to copy the patient's PCM data to the current family member. The system then prompts you to enter the family member's enrollment data as described in the "Enrollment" section above, except that you are prompted to enter PCM and OHI data only if the patient's PCM or OHI data were not copied to the current family member as described above.

After you have enrolled all the family members, the system returns you to the Demographics Display action bar.

Family Enrollment - Individual Family Members – A list displays all family members. All unenrolled family members are marked as unselected, and the system prompts you to select those family members who are to be enrolled. Then the system prompts you to enroll each selected family member as described above in the Family Enrollment section. The system then returns to the Demographics Display screen.

Enroll Family Members Into the MCP Using the Family Action

- **Data Entry Process**

Enter the patient name

Confirm the patient name

Display Current DEERS Eligibility for family member

Display the Demographics Display screen

Select family member(s) to enroll

Copy OHI information

Enroll family member

– **Complete the second MCP Enrollment screen**

Print the enrollment form

Print the patient address label

Enter the patient name

Confirm the patient name

This prompt refers to the family member who is already enrolled in MCP. It does not necessarily refer to the sponsor of the family member who is about to be enrolled.

Press <Return> to accept the current sponsor.

Display Current DEERS Eligibility for family member

Because a DEERS check was processed for this patient within the last five days, the Current DEERS Eligibility screen displays. Refer to Figure 5-31. Current DEERS Eligibility for Family Member, page 5-79.

```
                          CURRENT DEERS ELIGIBILITY
                  Name: PATRICK,ZELDA E               FMP/SSN: 30/637-24-9618
        Patient Category: USN FAM MBR AD                  DDS: 30
                 DOB/Age: 07 May 1971/30Y                 Sex: FEMALE

            Sponsor Rank: CHIEF PETTY OFFICER
             Sponsor UIC: N47673-DIA
                 DMIS ID: 0037-WALTER REED AMC
                     ACV: E-TRICARE PRIME (CHAMPUS)
          ACV Start Date: 11 Mar 1999              Region Code: 02
  Care Authorization PH#: 555-2349                PCM Location: DIRECT CARE PC
             Direct Care: ELIGIBLE                    Medicare: NOT ELIGIBLE
Dir Care Elig Start Date: 12 Mar 2001                 CHAMPUS: ELIGIBLE
  Dir Care Elig End Date: 10 Feb 2003
  Eligibility End Reason:

                                     BRAC Pharmacy Eligibility: NO
           Override Code:
         Date of Request: 17 Jun 2001

Select to (V)iew more DEERS data, (P)rint, (R)epeat DEERS check, (C)ontinue,
       or (Q)uit: C//
```

Figure 5-31. Current DEERS Eligibility for Family Member

Select the (C)ontinue action at the Current DEERS Eligibility screen.

Display the Demographics Display screen

The Demographics Display screen displays with the specified patient's information. Refer to Figure 5-32. Demographics Display Screen, page 5-80.

```
                              DEMOGRAPHICS DISPLAY
                  Name: PATRICK,ZELDA E              FMP/SSN: 30/637-24-9618
      Patient Category: USN FAM MBR AD                   DDS: 30
          Patient Type: MCP/CHAMPUS ELIGIBLE             Sex: FEMALE
            MCP Status: ENROLLED                      DOB/Age: 07 May 1971/30Y
                   ACV: E-TRICARE PRIME (CHAMPUS)     DMIS ID: 0037
           Direct Care: ELIGIBLE                     Medicare: NOT ELIGIBLE

          Sponsor Name: PATRICK,ZIGGY E                  Rank: CHIEF PETTY
OFFICE
          Station/Unit: DEFENSE INTEL AGENCY SEA D       DSN:
          Home Address: 962 MOORE DR
                  City: BALTIMORE                      State: MARYLAND
              ZIP Code: 21210                    Home Phone: 410-555-1212
            Duty Phone: 202-555-7010             Work Phone:
  Registration Comment:
Last Registration Date: 09 Sep 1999@1011
Outpatient Record Room: OUTPATIENT RECORDS
       MCP Enroll Date: 01 Jul 2001          End Enroll Date: 30 Jun 2002
  Primary Care Manager: PEKNY,JAMES M              PCM Phone: 202 456-9878
           Primary OHI: BLUE CROSS/BLUE SHIELD, NC Case Mgmt: NO

Select (F)ull, (M)ini, (E)nrollment, (O)HI, (P)CM, Ca(s)e, F(a)mily,
       (D)isenroll, (H)istory, (N)ew Patient, or (Q)uit DEMOGRAPHICS: E//
```

Figure 5-32. Demographics Display Screen

Select the F(a)mily action on the Demographics Display screen. Using this action, the Family Enrollment screen displays. The action bar contained in the bottom Interact Window allows you to select from the following actions:

(A)ll Family Members - Enrolls one or more specified family members at one time.

(I)ndividual Members - Enrolls only one specified individual family member.

(Q)uit Family - Exits the screen.

Select family member(s) to enroll

A list of family members registered in CHCS displays in the bottom Select Window. Refer to Figure 5-33. Family Enrollment Screen, page 5-81. For each family member, the following information is also displayed: FMP/SSN, Sex, DOB, and Enrollment Status. Selectable family members with an unenrolled status are highlighted.

> **Note:** If no additional family members exist, the message - There are no other family members - displays in the bottom Select Window.

```
                              FAMILY ENROLLMENT
         Patient: PATRICK,ZELDA E                    FMP/SSN: 30/637-24-9618
Patient Category: USN FAM MBR AD                         DDS: 30
             PCM: FAM MED MTF                      PCM Phone: 202 456-9878
     Primary OHI: BLUE CROSS/BLUE SHIELD, NC            Date: 21 Jun 2001
------------------------------------------------------------------------------
-
   FMP/SSN         Family Member                    Sex     DOB       Status
------------------------------------------------------------------------------
-
   01/637-24-9618  PATRICK,ZACH N                    M   09 Jan 1995
   20/637-24-9618  PATRICK,ZIGGY E                   M   07 Oct 1969     E
   30/637-24-9618  PATRICK,ZELDA E                   F   07 May 1971     E




------------------------------------------------------------------------------
-
Select (A)ll Family Members, (I)ndividual Members, or (Q)uit FAMILY: A// I
```

Figure 5-33. Family Enrollment Screen

1. Select the (I)ndividual Members action on the Family Enrollment screen.

   Use <Select> to select the family member to be enrolled and press <Return> to activate the selection.

2. If the enrollee is a family member of active-duty, the *Relationship to Insured* prompt displays.

Copy OHI information

The prompt *Do you want to copy OHI to [family member]? NO//* displays. Only non-active-duty family members have OHI information. Enter YES to copy the specified patient's insurance information to the family member you are enrolling.

Be careful when copying active-duty sponsor data to a family member as the sponsor may not reside with the family. Addresses can be changed in DEERS, incorrectly causing problems with mailings to the family.

Enroll family member

The MCP Enrollment - Continuation screen displays. Refer to Figure 5-34. MCP Enrollment - Continuation Screen, page 5-82. The cursor is positioned at the Patient Type field.

```
ENROLLMENT HISTORY: 01 Jul 2001                  MCP Enrollment -- CONTINUATION


                 Name: PATRICK,ZACH N                    FMP/SSN: 01/637-24-9618
     Patient Category: USN FAM MBR AD                        DDS: 30
         Patient Type: MCP/CHAMPUS ELIGIBLE                  Sex: MALE
           MCP Status:                                     DOB/Age: 09 Jan
1995/06Y
 Primary Care Manager: FAM MED MTF                     PCM Phone:
          Primary OHI: NOT ASSIGNED                    Case Mgmt: NO
                  ACV: E-TRICARE PRIME (CHAMPUS)    Direct Care: ELIGIBLE
   Enrolling Division:                                  Medicare:
 ================================================================================

         Patient Type: MCP/CHAMPUS ELIGIBLE

      MCP Enroll Date: 01 Jul 2001
      End Enroll Date: 30 Jun 2002

   Enrollment Comment:



Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 5-34. MCP Enrollment - Continuation Screen

1. Patient Type

   The patient type is derived by the system based on the patient's PATCAT, ACV code, and age. For this example, press <Return> to accept the system-derived data in the field.

2. MCP Enroll Date

   Press <Return> to accept the displayed default of the first day of the coming month as start of the enrollment date. You may edit the field with a date in the past or future. The default for active-duty is today and for non-active-duty, the default is the first day of the coming month.

3. End Enroll Date

   Press <Return> to accept the system-defaulted end enrollment date. This will be one year from the Enroll date for non-active-duty or the DEERS end of eligibility for active-duty.

4. Enrollment Comment

   Press <Return> to exit this field without making an entry, or enter an enrollment comment, using from 1 to 50 characters. The second MCP Enrollment screen displays. Refer to Figure 5-35. Second MCP Enrollment Screen, page 5-83.

Complete the second MCP Enrollment screen

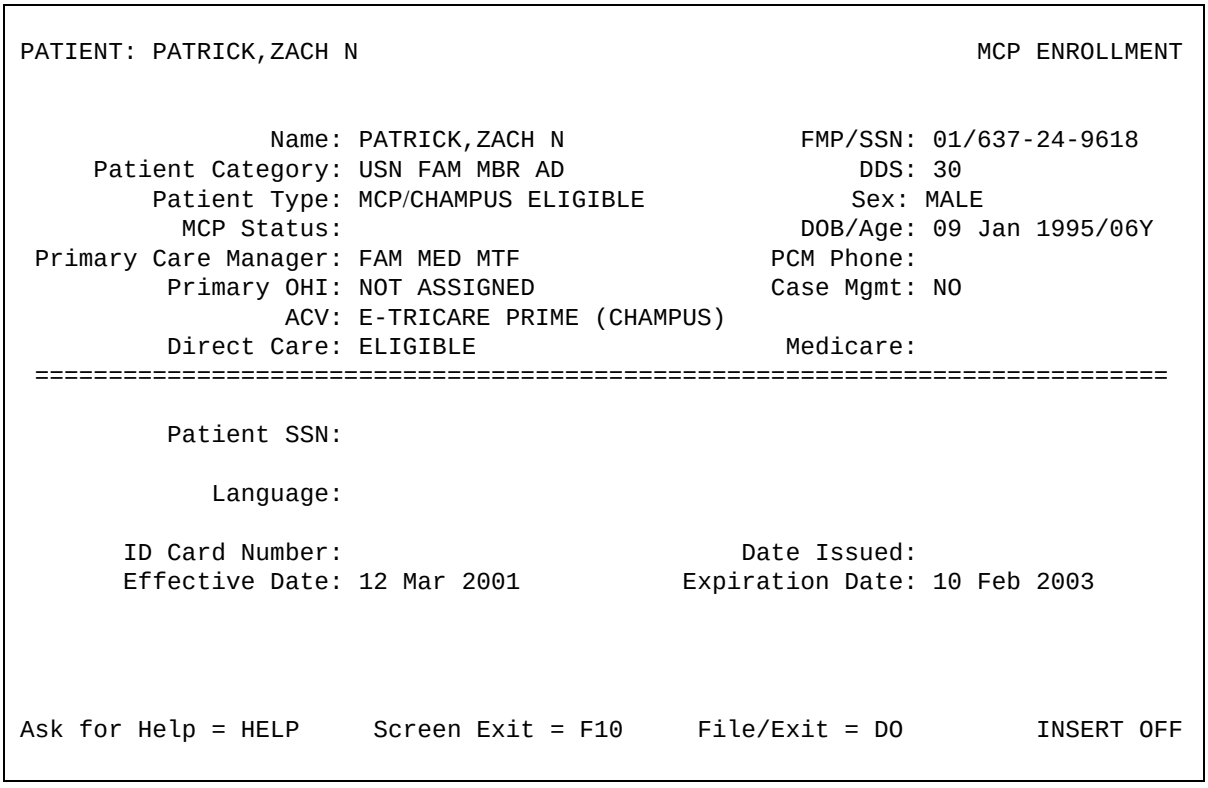


Figure 5-35. Second MCP Enrollment Screen

1. Language

   Enter the primary language spoken by the patient or press <Return> to leave this field blank. You do not need to enter English, because the system automatically assumes that all patients can communicate in English, unless otherwise specified.

2. ID Card Number

   Enter the beneficiary's ID card number.

3. Date Issued, Effective Date, and Expiration Date

   Enter the issue date, effective date, and expiration date imprinted on the ID card.

4. File the data.

   A message displays that the PCM is being copied.

Print the enrollment form

1. Enter "Yes" to print the enrollment form and select the output device.

Print the patient address label

1. Enter "Yes" to print a single label for the patient and select the output device.
2. (Q)uit the Family Enrollment screen

   The Demographics Display screen displays.

3. (Q)uit the Demographics Display screen.

5.1.6 Assign an Exception Provider to an MCP Patient

Menu Path: PAS System Menu → M → EMCP → EENR

- **Application Description**

Case Management - You can only access this action if the patient is enrolled in MCP. You are prompted either to enter/edit an exception provider or to quit this action and return to the action bar. Case Management providers must be HCPs in the Provider file.

The system permits you to access this action only if the patient has already been enrolled. The Case Management selection appears on the action bar when applicable. If the specified patient has a case management provider, the system automatically defaults the name of the case management provider at the *Select PROVIDER* prompt. The health care finder (HCF) can accept the default or enter the name of a different provider. However, the provider whose name is entered must have an agreement type that accepts the patient's specified patient type. The provider must be entered in the Provider files in CHCS. For this reason, if the case manager is not a provider, then it might be better not to enter that enrollee.

The system prompts you either to enter/edit an exception provider or to quit this action and return to the action bar of the option from which you entered this action.

Case Management (Enter/Edit Exception Provider) - Existing exception providers display, if any, then you are prompted to enter a new exception provider or select an existing one to edit. (Using <F9>, you may query the history of an existing provider before selecting the provider record.) In either case, the system prompts you to enter or edit the exception provider data, including provider phone, provider specialty, start date, stop date, and condition.

After the above process is complete, the system permits you either to enter or edit another exception provider or quit this action and return to the action bar of the option where case management was selected.

Assign an Exception Provider to an MCP Patient

- **Data Entry Process**

Enter the patient name

Confirm the patient and sponsor name

Display the Current DEERS Eligibility screen

Select the update action

Enter an exception provider name

Complete the MCP Exception Information - Continuation screen

View the patient's exception provider history on the Case Management - Enter/Edit screen

Exit the option

Enter the patient name

Confirm the patient and sponsor name

Press <Return> to accept the patient's current sponsor.

Display the Current DEERS Eligibility screen

The Current DEERS Eligibility screen displays.

The Demographics Display screen displays.

Select the Ca(s)e action on the Demographics Display screen.

Select the update action

The Case Management screen displays. Refer to Figure 5-36. Case Management Screen, page 5-87. You may enter a new exception provider or edit the information for an existing exception provider. The patient must be an enrollee.

The middle Select Window displays any exception providers currently assigned to the patient. For each provider, the specialty start date (to begin authorized care) and stop date (to end authorized care) also display.

If the patient currently does not have any exception providers, the message. *No Exception Providers Assigned* - displays in the bottom Select Window.

```
                              CASE MANAGEMENT
         Patient: PATRICK,ZELDA E                    FMP/SSN: 30/637-24-9618
Patient Category: USN FAM MBR AD                         DDS: 30
    Patient Type: MCP/CHAMPUS ELIGIBLE                   Sex: FEMALE
      MCP Status: PENDING ENROLLMENT                 DOB/AGE: 07 May 1971/30Y
             PCM: FAM MED MTF                           Date: 21 Jun 2001
--------------------------------------------------------------------------------
-
    Exception Provider       Specialty                Start Date    Stop Date




                        No Exception Providers Assigned
Select (E)nter/edit Exception Provider, or (Q)uit Case: E//
```

Figure 5-36. Case Management Screen

1. Select the Enter/edit Exception Provider action on the Case Management screen.

2. Enter Exception Provider.

The Case Management - Enter/Edit screen displays. Refer to Figure 5-37. Case Management Enter/Edit Screen, page 5-88. The cursor is positioned in the middle Select Window preceding the prompt <--- *Enter Exception Provide*r.

```
                          CASE MANAGEMENT - ENTER/EDIT
         Patient: PATRICK,ZELDA E                     FMP/SSN: 30/637-24-9618
Patient Category: USN FAM MBR AD                          DDS: 30
    Patient Type: MCP/CHAMPUS ELIGIBLE                    Sex: FEMALE
      MCP Status: PENDING ENROLLMENT                   DOB/AGE: 07 May 1971/30Y
             PCM: FAM MED MTF                             Date: 21 Jun 2001
--------------------------------------------------------------------------------
-
    Exception Provider       Specialty                Start Date    Stop Date

                             <--- Enter Exception Provider




Enter a new Exception Provider or Press <RETURN> to continue
```

Figure 5-37. Case Management Enter/Edit Screen

Enter an exception provider name

> **Note:** You may only enter a non-network provider from the MCP Provider Group Profile.

1. Confirm the provider name.

2. Confirm the addition of the exception provider.

   Enter NO if you want to reject the exception provider name and return to the Case Management - Enter/Edit screen. For this example, enter YES to confirm the provider.

The MCP Exception Information - Continuation screen displays. Refer to Figure 5-38. MCP Exception Information - Continuation Screen, page 5-89.

Complete the MCP Exception Information - Continuation screen

The MCP Exception Information - Continuation screen is divided into two parts. The top half displays the patient demographic data entered previously. The bottom half displays fields to be edited with case management information. The Exception Provider field is defaulted with information entered in the previous screen.

```
EXCEPTION PROVIDER: PHARIS,DARNELL C   MCP EXCEPTION INFORMATION --
CONTINUATION


                 Patient: PATRICK,ZELDA E              FMP/SSN: 30/637-24-9618
        Patient Category: USN FAM MBR AD                   DDS: 30
            Patient Type: MCP/CHAMPUS ELIGIBLE             Sex: FEMALE
              MCP Status: PENDING ENROLLMENT           DOB/AGE: 07 May 1971/30Y
                     PCM: FAM MED MTF                     Date: 21 Jun 2001
 ============================================================================
      Exception Provider: PHARIS,DARNELL C               Phone: 301 644-1232
      Provider Specialty:
              Start Date: T
               Stop Date:

               Condition:


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 5-38. MCP Exception Information - Continuation Screen

1. Exception Provider

   This field is automatically entered from a previous screen. You cannot edit this field.

2. Phone

   The Phone field defaults from the information maintained in the system provider file for this provider. Press <Return> to accept this information.

3. Provider Specialty

   Enter the specialty for this provider. Only specialties that are currently defined in the Provider file for this provider can be entered. To display a complete list of specialties, enter a double question mark (??).

4. Start Date

   Enter the date for which the patient is authorized to begin receiving care from this exception provider, or press <Return> to accept the default of today's date. For this example, press <Return>.

5. Stop Date

   Enter the date for which the patient is no longer authorized to receive care from this exception provider.

6. Condition

   Enter an optional comment explaining the patient's medical condition requiring the specialized care from this exception provider.

7. File the data.

The Case Management - Enter/Edit screen with the exception providers assigned displays. Refer to Figure 5-39. Case Management Enter/Edit Screen - View Provider Information, page 5-91. At this point, you may enter another exception provider name, edit the existing exception provider information, or view the patient's exception provider history.

View the patient’s exception provider history on the Case Management - Enter/Edit screen

For the specified exception provider, the screen displays the Exception Provider Name, Specialty, Start Date, Stop Date, Phone Number, and Condition.

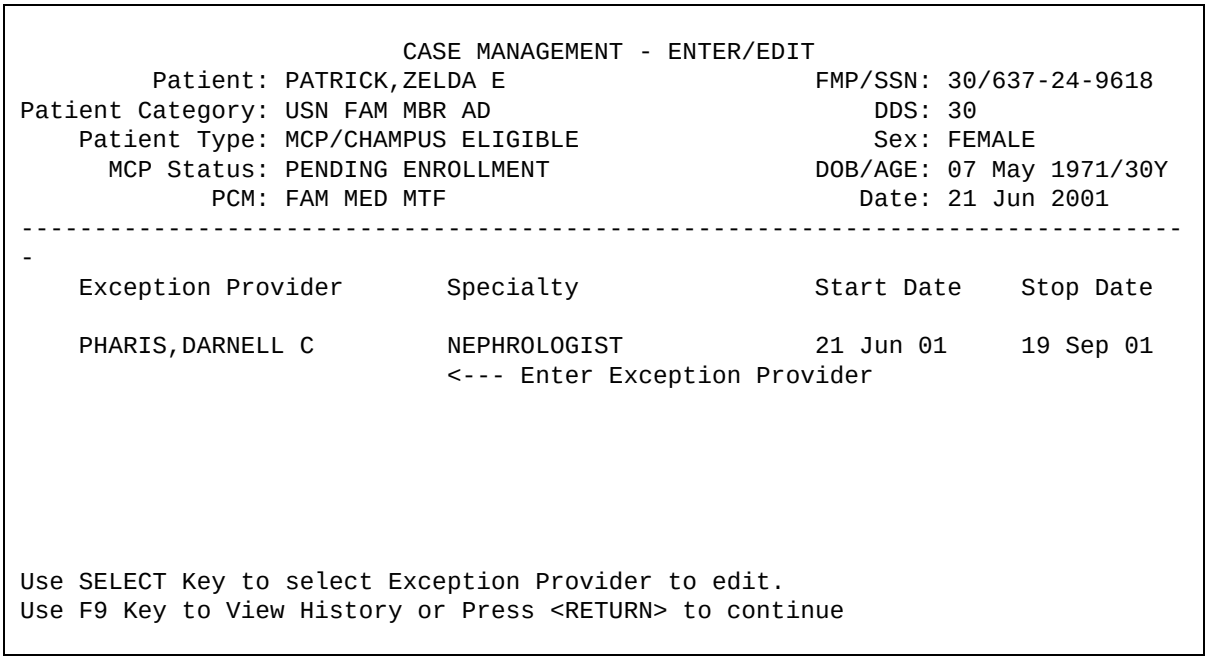


Figure 5-39. Case Management Enter/Edit Screen - View Provider Information

Position the cursor next to the exception provider you want and press <F9> to display the Case Management Condition screen.

1. (Q)uit the Case Management Condition screen.
2. (Q)uit the Case Management - Enter/Edit screen.
3. (Q)uit the Case Management screen.
4. (Q)uit to exit the Demographics Display screen.

Exit the option

The Enrollment Processing Menu displays.

5.1.7 Renew a Patient's Enrollment

Menu Path: PAS System Menu → M → EMCP → EENR

- **Application Description**

Enrollment Renewal Policies and Procedures - Before renewing a patient's MCP enrollment episode, be sure to check the specific policies and procedures with the Benefits Office at your site. Enrollment renewal may have associated fees or other patient and site requirements. Access the Enrollment Enter/Edit (EENR) option on the Enrollment Processing Menu. Health Affairs (HA) policy dictates that each renewal be entered for each individual. A renewal simply extends the end enrollment date out one year. No transaction goes to DEERS.

Renewing a Patient's Enrollment - You can renew enrollments for non-active-duty beneficiaries (CHAMPUS eligible beneficiaries only) at your facility who have a current enrollment episode that expires within a year from today.

The Renew action displays on the Demographics Display action bar when you attempt to enroll a patient who is currently enrolled as of today and whose current enrollment episode has not been renewed. The Renew action does not display for those beneficiaries with a status of Conditionally Enrolled, Pending Enrollment, Invalid Enrollment, or Ineligible. The renew action displays for 20 days after expiration to allow a grace period to receive and process enrollments. If not received, CHCS disenrolls the patient after 20 days.

When you renew a patient's enrollment, the system automatically extends the enrollment end date one year from the current enrollment end date, to a last day of the month. Once you renew a patient's enrollment episode, the Renew action no longer displays for that patient until their enrollment once again needs to be renewed. This prevents you from renewing a patient's enrollment years into the future without collecting the necessary fees.

Renew a Patient's Enrollment

- **Data Entry Process**

Enter the patient name

Renew the enrollment

View renewal dates and enter comment

Enter the patient name

1. Enter the patient's name and select the correct patient.
2. Confirm the patient name.
3. Confirm the sponsor name.

   The Family Member screen displays.

Renew the enrollment

1. Confirm that you are renewing the patient enrollment.

The Demographics Display screen displays.

View renewal dates and enter comment

The MCP Renewal - Continuation screen displays. Refer to Figure 5-40. MCP Renewal - Continuation Screen, page 5-95.

```
ENROLLMENT HISTORY: 01 Mar 2001                    MCP Renewal -- CONTINUATION


                Name: PEARL,ALEXANDER E                FMP/SSN: 04/469-69-
4415
     Patient Category: USN FAM MBR AD                      DDS: 4
         Patient Type: MCP/CHAMPUS ELIGIBLE                Sex: MALE
           MCP Status: ENROLLED                         DOB/Age: 12 Mar
1996/05Y
 Primary Care Manager: PELLES,LOUIS M                PCM Phone: 202 456-9878
          Primary OHI: NOT ASSIGNED                  Case Mgmt: NO
                  ACV: E-TRICARE PRIME (CHAMPUS)   Direct Care: ELIGIBLE
   Enrolling Division: DIV A                          Medicare: NOT ELIGIBLE
 ================================================================================

         Patient Type: MCP/CHAMPUS ELIGIBLE

      MCP Enroll Date: 01 Mar 2001
      End Enroll Date: 30 Jun 2002

   Enrollment Comment:

Ask for Help = HELP   Screen Exit = F18   File/Exit = DO
```

Figure 5-40. MCP Renewal - Continuation Screen

1. End Enroll Date

   The end enroll date is already extended one year to an end-of-month date and cannot be edited.

2. Enrollment Comment

   You can enter an enrollment comment, but you cannot edit the enrollment dates.

3. File the data.

   The Demographics Display screen displays.

4. (Q)uit to exit the Demographics Display screen.

   Refer to Figure 5-6. Demographics Display Screen, page 5-21.

5.1.8 TRICARE Senior Enrollment

Follow the same steps as above to enroll Medicare-eligible beneficiaries into the TRICARE Senior Option. Refer to Section 5.1.1 Enroll a Patient, page 5-7, and Section 5.1.2 Assign a PCM, page 5-48. The system automatically searches as follows for PCMs who have remaining capacity for Medicare beneficiaries:

1. The system first checks to see if the beneficiary is Medicare eligible. The system categorizes patients who are Medicare eligible as determined by DEERS Medicare status. If the beneficiary is Medicare eligible, the system then checks the beneficiary's age; and finally, checks to see if the beneficiary is CHAMPUS eligible.

   A Medicare- and CHAMPUS-eligible beneficiary, regardless of age, continues to be grouped under the appropriate Beneficiary Category and is NOT grouped under the Medicare Category. After establishing the appropriate Beneficiary Category under which the beneficiary is grouped, the system checks for available PCM slots for that category. If slots are available, the system allows you to enroll the beneficiary into one of the available slots; the counts for the enrollee patient load for the Beneficiary Category under which a beneficiary is grouped is incremented by one; and the beneficiary is assigned an ACV of "E."

   If there are no slots available which meet the search criteria, a warning message displays (including the actual Beneficiary Category) to inform you that there are no slots to which this individual may be assigned. If no slots are available, the system prohibits filing the enrollment.

2. A Medicare-eligible beneficiary, 65 years of age or older, and not CHAMPUS eligible, is categorized under the Medicare Beneficiary Category. When the system determines that a beneficiary is in the Medicare Beneficiary Category, it checks to see if there are any PCMs in the Network who have MTF or CON MCP Agreement Types, and have available Medicare slots, as determined by their Enrollment Mix limitations.

   If slots are available, the system allows you to enroll the beneficiary under the Medicare Beneficiary Category; the counts for the Medicare enrollee patient load is incremented by one; and the beneficiary is assigned an ACV of "D."

   If there are no slots available that meet the search criteria, a warning message displays including "Medicare Category," to inform you that there are no slots to

which this individual may be assigned. If no slots are available, the system prohibits filing the enrollment.

3. You are prohibited from enrolling Direct Care Only beneficiaries, (including Medicare, under the age of 65), who are not CHAMPUS eligible.

5.2 Enrollment Cancellation (ECAN)

Menu Path: PAS → M EMCP → ECAN

- **Security Keys**

  CPZ CCP

- **Required Fields**

  Patient Name

- **Application Description**

The Enrollment Cancellation (ECAN) option allows you to cancel enrollments with the following enrollment status:

– a confirmed DEERS enrollment for a future date (Pending Enrollment)

– a confirmed current DEERS enrollment (Enrolled)

– a confirmed DEERS enrollment with an invalid disenrollment transaction (Invalid Disenrollment).

This option automatically sets the disenrollment reason to “Enrollment Canceled” and updates the enrollment end date to equal the enrollment start date. Enrollments cannot be canceled through any other MCP option. The ECAN option only allows you to cancel enrollments for individual patients. Enrollment cancellations cannot be processed for an entire family and enrollment cancellations cannot be batched.

Enrollment cancellations can only be processed by users with access to the CHCS enrolling division associated with the enrollment record.

If the site is operating in DEERS Enrollment mode, a message is transmitted to notify the DEERS system that the enrollment has been canceled. Site personnel are responsible for addressing enrollment cancellations that may return a discrepancy response from DEERS/

- **Business Rules**
  - Enrollment Cancellation is allowed only for those CHCS patients who have a future enrollment record (MCP Status = PENDING ENROLLMENT) or current enrollment record (MCP Status = ENROLLED, INVALID ENROLLMENT, INVALID DISENROLLMENT) in CHCS.
  - Canceled enrollments that are automatically set with the enrollment end date equal to the enrollment start date. The disenrollment reason is automatically set to “Enrollment Canceled”. You cannot edit these values.
  - The MCP Status of “Disenrolled” (D) is assigned to enrollment records that have been successfully canceled.
  - An enrollment history record that has been canceled in CHCS is reused if the patient is reenrolled at the MTF. Note that enrollment cancellation history segments are deleted in DEERS.
  - Existing business rules to transmit cancellation transactions to DEERS are used. If in Local Empanelment mode, enrollment cancellation transactions are sent to DEERS only for active-duty enrollees. If in DEERS Enrollment mode, enrollment cancellation transactions are sent to DEERS for all enrollees (active-duty, retirees, family members of active-duty, family member of retirees, and other).
  - DEERS allows enrollment cancellation only for the current segment. In addition, only the enrolling division may process the enrollment cancellation.

Cancel an Enrollment

- **Data Entry Process**

Access the ECAN option

Select the patient

Review DEERS eligibility

Cancel the enrollment

Verify cancellation

Exit the option

Access the ECAN option

The system prompts you to enter the patient name.

Select the patient

Refer to Figure 5-41. Enrollment Cancellation Initial Prompt, page 5-98.

```
ENROLLMENT CANCELLATION PROCESSING


Select PATIENT NAME: BIEGLER,DIANE     30/534-48-2446 06 Seep 1955 F
         OK? YES//   (YES)
SPONSOR NAME: BIEGLER,EDWARD J//
```

Figure 5-41. Enrollment Cancellation Initial Prompt

1. Enter patient name.

2. Press <Return> to verify that this is the correct patient.

3. Press <Return> to verify that this is the correct sponsor.

If a DEERS check has been processed for this patient within the past five days, the Current DEERS Eligibility screen displays. Refer to Figure 2-b. Current DEERS Eligibility. For additional information about the Current DEERS Eligibility screen, refer to Section 4, DEERS Functions and Processes.

Review DEERS eligibility

```
                          CURRENT DEERS ELIGIBILITY

           Name: BIEGLER,DIANE                          FMP/SSN: 30/534-48-2446
Patient Category: USAF FAM MBR RET                          DDS: 30
         DOB/AGE: 06 Sep 1955/41Y                           Sex: FEMALE
_____________________________________________________________________________
_
            Sponsor Rank: MASTER SERGEANT
             Sponsor UIC: RETSP-RETIRED SPONSOR
                 DMIS ID: 0103-NH CHARLESTON
                     ACV: E-TRICARE PRIME (CHAMPUS)
          ACV Start Date: 01 Sep 1997              Region Code: 03
  Care Authorization PH#: 0000000000             PCM Location: DIRECT CARE
             Direct Care: Eligible PC                Medicare: NOT ELIGIBLE
Dir Care Elig Start Date: 31 Aug 1974                 CHAMPUS: ELIGIBLE
  Dir Care Elig End Date: 08 Aug 1998
  Eligibility End Reason: P-ID Card Expiration

                                          BRAC Pharmacy Eligibility:
           Override Code:
         Date of Request: 01 Sep 1997
_____________________________________________________________________________
_

Select to (V)iew more DEERS data,(P)rint,(R)epeat DEERS check, C)ontinue,
       Or (Q)uit: C//
```

Figure 5-42. Current DEERS Eligibility Screen

Select (R)epeat DEERS check.

If a DEERS check has not been processed for this patient within the past five days or if you choose to repeat the DEERS check, a message displays indicating that a DEERS request is being processed. Refer to Figure 5-43. DEERS Processing Message, page 5-100.

Note: The data displayed on the Current DEERS Eligibility screen does not necessarily reflect the most current data in DEERS since changes may have been entered into DEERS since the check was performed. It is recommended that you repeat the DEERS check to ensure you have the most current data prior to canceling an enrollment. This process allows you an opportunity to correct sponsor information errors in CHCS that might result in an MCP status of Invalid Disenrollment.

Also, though a DEERS check is automatic if there has not been a DEERS check processed for the patient within the past five days, the check is not mandatory. You may batch the request or quit the process and continue the cancellation without a DEERS check.

```
CHCS-DEERS                  Processing DEERS Request


Waiting To Process.
Processing Request...



     Press 'B' to batch this DEERS request, or
           'Q' to quit and not process this DEERS request.
```

Figure 5-43. DEERS Processing Message

When you allow the DEERS request to be processed, the DEERS Eligibility Data screen displays. Refer to Figure 5-44. DEERS Eligibility Data Screen, page 5-101. This screen displays the most up-to-date information filed in DEERS. For additional information about the DEERS Eligibility Data screen, refer to Section 4, DEERS Functions and Processes.

```
                          DEERS ELIGIBILITY DATA
                 Name: BIEGLER,DIANE                    FMP/SSN: 30/534-48-
2446
     Patient Category: USAF FAM MBR RET                     DDS: 30
              DOB/Age: 06 Sep 1955/41Y                      Sex: FEMALE
_____________________________________________________________________________
__
                    NAME: BIEGLER,DIANE
                     SEX: FEMALE                            DOB: 06 Sep 1955
                     DDS: 30                        Sponsor SSN: 534-48-2446
                     ACV: E-TRICARE PRIME (CHAMPUS)
          ACV Start Date: 01 Sep 1997               Region Code: 03
                  DMIS ID: 0103-NH CHARLESTON
  Care Authorization PH#: 0000000000              PCM Location: DIRECT CARE
PC
            Sponsor Rank: MASTER SERGEANT
             Sponsor UIC:
             Direct Care: ELIGIBLE                    Medicare: NOT ELIGIBLE
Dir Care Elig Start Date: 31 Aug 1974                  CHAMPUS: ELIGIBLE
  Dir Care Elig End Date: 08 Aug 1998
  Eligibility End Reason: P-ID Card Expiration

                                          BRAC Pharmacy Eligibility:
_____________________________________________________________________________
__

Select to (V)iew more DEERS data, (H)istorical DEERS, (P)rint, (C)ontinue,
       or (Q)uit: C//
```

Figure 5-44. DEERS Eligibility Data Screen

Accept the default (C)ontinue action.

If discrepancies exist between CHCS data and DEERS data, the CHCS/DEERS Discrepancy Data screen displays. Refer to Figure 5-45. CHCS/DEERS Discrepancy Data Screen, page 5-102. The data discrepancies are highlighted in the middle Select Window. Refer to Section 4, DEERS Functions and Processes for a complete explanation of the CHCS/DEERS Discrepancy Data screen.

```
                        CHCS/DEERS DISCREPANCY DATA
             Name: BIEGLER,DIANE                          FMP/SSN: 30/534-48-2446
  Patient Category: USAF FAM MBR RET                          DDS: 30
       MCP Status: PENDING ENROLLMENT                      DOB/Age: 06 Sep
1955/41Y
              ACV: E-TRICARE PRIME (CHAMPUS)               DMIS ID: 0103
      Direct Care: ELIGIBLE                               Medicare: NOT ELIGIBLE
-------------------------------------------------------------------------------
--
                    CHCS Data                              DEERS Data
_____________________________________________________________________________
__

   Name           : BIEGLER,DIANE
   DOB            : 06 Sep 1955                           06 Sep 1955
   Sex            : FEMALE                                FEMALE
   Patient SSN    : 800-55-0906

   Sponsor Rank   : MASTER SERGEANT                       MASTER SERGEANT
   PatCat/Status  : F31-RETIRED                           ACTIVE-DUTY
   Station/Unit   : RETSP-RETIRED SPONSOR                 N6172062
_____________________________________________________________________________
_

Select (U)pdate CHCS, (P)rint Discrepancies, (C)ontinue, or (Q)uit: C//
```

Figure 5-45. CHCS/DEERS Discrepancy Data Screen

1. Accept the default (U)pdate CHCS.

   The system replaces the CHCS/DEERS Discrepancy Data action bar with the *Use SELECT key to select CHCS data to update* prompt and moves the cursor to the middle Select Window.

2. Position the cursor beside the field(s) you want to update in CHCS and press <Return>.

   The CHCS/DEERS Discrepancy Data screen redisplays with only the selected fields displayed and replaces information in the bottom Interact Window. Refer to Figure 5-46. Caution Message, page 5-102.

```
     _____CAUTION: Data selected will be changed in CHCS files _________

Are you sure you want to update the CHCS data with the DEERS data? NO//
```

Figure 5-46. Caution Message

1. Accept the No default or enter "Y" for YES, then press <Return> to continue.

   The Demographics Display screen displays. Refer to Section 6 for a sample Demographics Display screen and full explanation of the data.

2. Press <Return> to continue.

   The MCP Enrollment Cancellation screen displays. Refer to Figure 5-47. MCP Enrollment Cancellation Screen, page 5-103.

Cancel the enrollment

```
ENROLLMENT HISTORY: 01 Sep 1997                      MCP Enrollment
Cancellation

                  Name: BIEGLER,DIANE              FMP/SSN: 30/534-48-2446
       Patient Category: USAF FAM MBR RET              DDS: 30
           Patient Type: MCP/CHAMPUS ELIGIBLE        Sex: FEMALE
             MCP Status: PENDING ENROLLMENT         DOB/Age: 06 Sep 195541Y
   Primary Care Manager: BERNSTEIN,BERNARD        PCM Phone: 619-555-1212
            Primary OHI: NOT ASSIGNED             Case Mgmt: NO
                    ACV: E-TRICARE PRIME (CH    Direct Care: ELIGIBLE
     Enrolling Division: A DIVISION (OK)           Medicare: NOT ELIGIBLE
_____________________________________________________________________________
__

           Patient Type: MCP/CHAMPUS ELIGIBLE

        MCP Enroll Date: 01 Sep 1997
        End Enroll Date: 31 Aug 1998

     Enrollment Comment:

_____________________________________________________________________________
_

Select (N)ew Patient, (E)nrollment History, (C)ancel Enrollment, or (Q)uit:
C//
```

Figure 5-47. MCP Enrollment Cancellation Screen

The MCP Enrollment Cancellation screen has three windows. The top Display Window indicates that the MCP status is Pending Enrollment and that A Division is the enrolling division. This patient's MCP status of Pending Enrollment (confirmed DEERS enrollment

for a future date) qualifies the enrollment to be canceled through the ECAN option by users with access to A Division.

The middle Select Window displays patient type, MCP enroll date, MCP end enroll date, and enrollment comments, if any.

The bottom Interact Window contains an action bar with the following actions:

- **(N)ew Patient -** Returns you to the initial prompt.
- **(E)nrollment History -** Displays the Enrollment History screen, which lists enroll date(s) any associated disenroll dates and disenrollment reasons.
- **(C)ancel Enrollment -** Asks you to verify that you want to cancel the enrollment for the selected patient.
- (Q)uit - Returns you to the Enrollment Processing Menu.

Accept the default (C)ancel Enrollment.

You are prompted to verify that you want to cancel this patient's enrollment. Refer to Figure 5-48. Verify Cancellation Screen, page 5-104.

Verify Cancellation

```
ENROLLMENT HISTORY: 01 Sep 1997                    MCP Enrollment
Cancellation


                          VERIFY CANCELLATION

_____________________________________________________________________________
_

                  Name: BIEGLER,DIANE          MP/SSN: 30/534-48-2446
             MCP Status: INVALID ENROLLMENT    DOB/Age: 06 Sep 1955/41Y

 ID: 0103-NH CHARLESTON
                   ACV: E-TRICARE PRIME (CHAMPUS)
   Primary Care Manager: BERNSTEIN,BERNARD
              PCM Phone: 619-555-1212
        MCP Enroll Date: 01 Sep 1997
        End Enroll Date: 31 Aug 1998

_____________________________________________________________________________
_

Do you want to cancel this enrollment for this patient? No//
```

Figure 5-48. Verify Cancellation Screen

1. Do you want to cancel this enrollment for this patient? No//

   Enter "Y" to override the No default. The following message displays in the bottom Interact Window.

   Canceling Enrollment for patient BIEGLER,DIANE...

   Press <RETURN> to continue

2. Press <Return> to continue.

   The system returns to the MCP Enrollment Cancellation screen. Refer to Figure 2-f. MCP Enrollment Cancellation Screen.

3. Select the (E)nrollment History action.

   The Enrollment History screen displays. Refer to Figure 5-49. Enrollment History, page 5-105.

```
                              ENROLLMENT HISTORY
         Patient: BIEGLER,DIANE                          FMP/SSN: 30/534-48-2446
Patient Category: USAF FAM MBR RET                           DDS: 30
    Patient Type: MCP/CHAMPUS ELIGIBLE                       Sex: FEMALE
      MCP Status: DISENROLLED                           DOB/AGE: 06 Sep
1955/41Y-
------------------------------------------------------------------------------
-
Enroll Date   Disenroll Date   Disenrollment Reason
_____________________________________________________________________________
_

01 Sep 97     01 Sep 97        ENROLLMENT CANCELED
01 Aug 95     22 Aug 95        MOVING (OTHER)


_____________________________________________________________________________
_

Select (D)isplay/Print Enrollment History, or (Q)uit: D//
```

Figure 5-49. Enrollment History

1. Select (D)isplay/Print Enrollment History or (Q)uit: D//

Accept the default (D)isplay/Print Enrollment History. The system moves the cursor to the first line in the middle Select Window and replaces the action bar with the following:

```
Use SELECT key to select enrollment history
```

2. Press <Select>, then press <Return> with the cursor positioned next to the line you want to expand.

3. Device

Enter device (printer) name or press <Return> to display to the screen.

4. Margin: 80//

   Accept the default 80 column margin.

The Display Enrollment History screen displays. Refer to Figure 5-50. Display Enrollment History Screen, page 5-106.

```
               Personal Data - Privacy Act of 1974 (PL 93-579)
                          DISPLAY ENROLLMENT HISTORY
             Patient: BIEGLER,DIANE                      FMP/SSN: 30/534-48-
2446
     Patient Category: USAF FAM MBR RET                      DDS: 30
         Patient Type: MCP/CHAMPUS ELIGIBLE                  Sex: FEMALE
           MCP Status: DISENROLLED                       DOB/Age: 06 Sep
1995/41Y
================================================================================
==
   Enrolling Division: A DIVISION (OK)
         Patient Type: MCP/CHAMPUS ELIGIBLE          Patient SSN: 800-55-0906
      MCP Enroll Date: 01 Sep 1997              Discrepancy Code: 99
 End Elig/Enroll Date: 01 Sep 1997              Transaction Type: AQC40
                  ACV: E-TRICARE PRIME (CHAMPUS)
              DMIS ID: 0103-NH CHARLESTON
   Enrollment Comment:
            Language:                           Transaction Date: 01 Sep 1997
       ID Card Number:                                Date Issued:
       Effective Date:                             Expiration Date:

 Primary Care Manager: BERNSTEIN,BERNARD               PCM Phone: 619-555-1212
           Case Mgmt: NO
         Primary OHI:
 Disenrollment Reason: ENROLLMENT CANCELED

        Enrolled Date: 27 Aug 1997
          Enrolled By: BRANNAN,PAMELA

   Last Modified Date: 01 Sep 1997
     Last Modified By: RANDALL,JEWEL

   PCM Date of Change:    PCM Name:                        PCM Changed By:
       25 Aug 1997        BERNSTEIN,BERNARD                RANDALL,JEWEL
```

Figure 5-50. Display Enrollment History Screen

Notice that the MCP Enroll Date and the End Elig/Enroll Date are now the same.

Exit the option

1. Press <Return> to exit the Display Enrollment History screen.

   The MCP Enrollment Cancellation displays. Refer to Figure 5-47. MCP Enrollment Cancellation Screen.

2. Press <Return> to accept the (Q)uit default and return to the Enrollment Processing Menu or enter N for (N)ew Patient and return to the initial prompt to process another enrollment cancellation.

5.3 Disenrollment (DENR)

Menu Path: PAS System Menu → M → EMCP → DENR

- **Security Keys**

  None identified

- **Required Fields**

  Patient name

- **Application Description**

The Disenrollment option allows you to disenroll MCP patients; e.g., when a patient leaves a catchment area. The system prompts you to enter the name of a patient registered in CHCS, and you can then disenroll any or all enrolled member(s) of the patient's family. For correct disenrollment, the start and end dates must be different.

When a patient is disenrolled through this option, the system clears that patient's Entitlement Discrepancy code, if present, which resolves any Entitlement Discrepancy condition. If you subsequently reenroll the patient, the enrollment start date is then compared to the ACV end date from the previous enrollment. The dates are automatically adjusted, when necessary, to prevent overlapping enrollment episodes.

Note: Input errors can affect a beneficiary's claim for payment and services. In CHCS Version 4.6, a new option allows a disenrollment to be corrected or to be canceled once it has been filed in CHCS. Refer to Section 5.4, Disenrollment Cancellation/Correction (DCAN).

Disenroll a Patient

- **Data Entry Process**

Access the DENR option

Select the patient name

Disenroll family members

Select the family member for disenrollment

Confirm patient to be disenrolled

Exit the option

Access the DENR option

Select the patient name

1. Enter name of patient to be disenrolled.
2. Confirm the patient name.
3. When the patient name is selected and confirmed, no DEERS check is performed. The Demographics Display screen displays.

The Demographics Display action bar is used to either access the Full Registration option in PAD, access the Mini Registration option in PAD, enter or edit the OHI policies of the patient with the Enrollment Enter/Edit option in PAS, select a New patient, or exit this phase of the option and continue to the Disenrollment screen. Refer to Figure 5-51. Disenrollment Screen, page 5-109.

Disenrollment - You may access this action only if the patient is already enrolled in CHCS. An action bar prompts you to disenroll All family members, disenroll Individual family

members, or Quit the disenrollment action and return to the Demographics Display action bar.

> **Note:** Before disenrollment, be sure to check the Family Member Response screen or the DEERS Eligibility Data screen in the Enrollment module to verify the patient ID in DEERS and if necessary, modify the patient ID in CHCS to match it. If the patient identification has changed since enrollment, DEERS may not recognize the patient and reject the disenrollment. The patient must be disenrolled with the same sponsor, SSN, DOB, and DDS that they were enrolled under. Be aware that DEERS does not store an "end enrollment date", only a "disenrollment date". The patient is enrolled in DEERS until CHCS sends a disenrollment to DEERS.

Disenroll family members

```
                          DISENROLLMENT
          Patient: PEARL,ZACHARY N.          FMP/SSN: 20/569-69-4415
 Patient Category: USN ACTIVE-DUTY               DDS:
       MCP Status:                             Date: 21 Jun 2001
------------------------------------------------------------------------
   FMP/SSN         Family Member           Sex    DOB     ENR Date     Status

20/569-69-4415 PEARL,ZACHARY N.          M 12 Jun 75









----------------------There are no other family members-----------------
Select (A)ll Family Members, (I)ndividual Family Members,
       or (Q)uit Family Disenroll: A//
```

Figure 5-51. Disenrollment Screen

The bottom Interact Window contains an action bar with the following actions:

- **(A)ll Family Members -** Displays all family members registered in CHCS. All family members enrolled in MCP are marked as selected, and the system prompts you to deselect those family members who are not to be disenrolled. If all family members are deselected, then no family members are disenrolled; the system returns to the action bar.
- **(I)ndividual Family Members -** Displays all family members registered in CHCS. All family members enrolled in MCP are marked as unselected, and the system prompts you

to select those family members who are to be disenrolled. Then the system prompts you to disenroll each selected family member.

– **(Q)uit Family Disenroll -** Returns you to the *Select PATIENT* prompt.

For both the (A)ll Family Members and (I)ndividual Family Members actions, if at least one family member is selected to be disenrolled, the system continues the process. For each family member (if any) who has pending appointments and/or wait list requests, the system prompts you to indicate whether to print the Display Patient Appointments report. Then you are prompted to indicate whether to disenroll the selected family member(s).

> **Note:** The disenrollment reason of "EC" may be used only to cancel enrollments in the ECAN option. You can no longer enter "EC" is disenrollment..

Select the family member for disenrollment

The Disenrollment screen displays a family picklist in the middle Select Window. For each member, the list displays the following information:

– FMP/SSN
– Sex
– DOB
– Enrollment Date
– Enrollment Status.

Those selectable family members with a current status of Enrolled, Pending Enrollment, Conditional Enrollment, or Invalid Disenrollment are highlighted.

> **Note:** If no additional family members exist, the message - There are no other family members - displays at the bottom of the middle Select Window.

Confirm patient to be disenrolled

Use <Select> to select the patient to be disenrolled and press <Return>.

> **Note:** If the specified patient has pending appointments, you are notified by a message at the bottom of the middle Select Window. You are also prompted whether to display or print the patient's appointments.

1. Enter Disenrollment Date: [default date]//

You must enter a disenrollment date. For an enrollment cancellation, enter the enrollment start date as the disenrollment date. This is a required field.

If you process a disenrollment for a past date, the system immediately updates the MCP status to Disenrolled until a successful response is returned from DEERS.

Disenrollments with a future enrollment date remain with an Enrolled status until the future date arrives.

A successful disenrollment response also triggers the system to update the ACV and DMIS ID. The ACV start date, ACV end date, and PCM Location Code are also updated based on data contained in the MCP patient file.

2. Enter Disenrollment Reason.

   The system automatically sends an MCP disenrollment transaction to DEERS. The Disenrollment screen displays.

   The following are valid disenrollment reasons. Reasons marked with an asterisk (*) cannot be entered.

DE	Disenrollment/Expiration
EC	Enrollment Canceled (cannot be entered in disenrollment)
EE	Enrolled in Error
GA	Griev/Complain - Accessibility
GB	Griev/Complaint - Benefits
GO	Griev/Complaint - Other
GP	Griev/Complaint - Providers
JO	Joined HMO/New OHI Coverage
*LE	Loss of Entitlement
MCS	Moving (to CRI Site)
MMM	Moving (to Non MCP Site)
MOM	Moving (to other MCP Site)
MV	Moving (Other)
PN	Provider Pref Not in Plan
*RD	Reciprocally Disenrolled
*RED	Reciprocally Enrolled/Disenrolled
*RM	Remotely Disenrolled
*TD	Termination of DEERS Enrollment Mode
*TL	Termination of Local Empanelment Mode.

Exit the option

5.4 Disenrollment Cancellation/Correction (DCAN)

Introduction

Menu Path: PAS → M→ EMCP → DCAN

- **Security Keys**

  CPZ DISENROLL CANCEL-CORRECT

- **Required Fields**

  Patient Name
  Enrollment End Date

- **Application Description**

The Disenrollment Cancellation/Correction (DCAN) option allows you to cancel or correct a disenrollment date (enrollment end date) for a patient's latest enrollment history. This option also transmits appropriate transactions to DEERS for sites operating in DEERS Enrollment mode. The MCP status is then updated based on the DEERS response.

An online DEERS eligibility check is recommended prior to canceling or correcting a disenrollment date (to verify that the patient has not been reenrolled); however, you can batch the eligibility check.

Disenrollment cancellations/corrections can only be processed if you have the CPZ DISENROLL CANCEL-CORRECT security key and access to the CHCS enrolling division associated with the patient's enrollment record.

Discrepancies that may result from canceling a disenrollment or correcting an enrollment end date are included in the Enrollment Disenrollment Discrepancy Report. Site personnel are responsible for addressing these discrepancies.

- **Business Rules**

– Only the latest CHCS enrollment record with the MCP status of Disenrolled may be canceled or corrected using the DCAN option. The enrollment end date associated with a current enrollment record (Enrolled and Pending Enrollment) may be corrected by using the Enrollment Enter/Edit option.

– Disenrollment cancellation/corrections cannot be processed for patients that are currently enrolled at another facility based on the DEERS eligibility response. Disenrollment cancellation/correction is allowed only for the most current enrollment segment on DEERS.

Cancel or Correct a Patient's Disenrollment Date

- **Data Entry Process**

Access the Disenrollment Cancellation/Correction (DCAN) option and select patient

Review DEERS Eligibility and Demographics Display screens

Cancel the Disenrollment or correct the disenrollment date

Exit the option

Access the Disenrollment Cancellation/Correction (DCAN) option and select patient

After you enter the patient name, you verify the patient and sponsor names. Refer to Figure 5-52. Verify Patient and Sponsor, page 5-113.

```
DISENROLLMENT CANCELLATION/CORRECTION PROCESSING


Select PATIENT NAME: BIEGLER,CAROLE    01/534-48-2446 31 Jul 1975 F
         OK? YES//   (YES)
SPONSOR NAME: BIEGLER,EDWARD J//
```

Figure 5-52. Verify Patient and Sponsor

1. Press <Return> at the *OK? YES//* prompt if the patient name, Patient category, sponsor SSN, patient date of birth and sex are correct.

2. Press <Return> at the *SPONSOR NAME: [SPONSOR NAME]//* prompt if the displayed sponsor name is correct for the selected patient.

The system automatically requests a DEERS check. Refer to Figure 5-53. Processing DEERS Request Screen, page 5-114.

```
CHCS-DEERS                  Processing DEERS Request

Waiting To Process
Processing Request.



     Press 'B' to batch this DEERS request, or
           'Q' to quit and not process this DEERS request.
```

Figure 5-53. Processing DEERS Request Screen

If you enter Q to quit and not process this DEERS request, the Disenrollment Cancellation/Correction screen displays, allowing you to cancel or correct the disenrollment for all the patient's family members, individual family members, or quit the DCAN option.

1. If you enter B to batch this DEERS request, Current DEERS Eligibility screen or the DEERS Eligibility Data screen displays.

Review DEERS eligibility and Demographics Display screens

If the last eligibility check was processed within the past five days, the Current DEERS Eligibility screen displays. If the last eligibility check was more than five days ago, the DEERS Eligibility Data screen displays. Refer to Figure 5-4. Current DEERS Eligibility, page 5-19, for a sample Current DEERS Eligibility screen and Figure 5-8. Sample DEERS Eligibility Data Screen for an Eligible Patient, page 5-26.

If there are discrepancies between DEERS data and CHCS data, the CHCS/DEERS Discrepancy Data screen displays, allowing you to update CHCS with the DEERS data, print the discrepancies, quit and exit the DCAN option or continue. Refer to Figure 5-7. CHCS/DEERS Discrepancy Data Screen, page 5-24.

After reviewing the DEERS eligibility data on either the Current DEERS Eligibility screen or the DEERS Eligibility Data screen and reviewing/updating the CHCS/DEERS discrepancies, press <Return> to continue. The Demographics Display screen displays allowing you to choose a new patient, continue, or quit. Refer to Figure 5-1. Demographics Display Screen, page 5-9.

When you choose the (C)ontinue action on the Demographics Display action bar, the Disenrollment Cancellation/Correction screen displays. Refer to Figure 5-54. Disenrollment Cancellation/Correction, page 5-115.

Cancel the Disenrollment or correct the disenrollment date

```
                DISENROLLMENT CANCELLATION/CORRECTION
         Patient: BIEGLER,CAROLE                FMP/SSN: 01/534-48-2446
Patient Category: USAF FAM MBR RET                  DDS: 1
      MCP Status: DISENROLLED                     Date: 26 Aug 1997
------------------------------------------------------------------------
FMP  Family Member          DOB       ACV  Start      End       Status
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
01  BIEGLER,CAROLE          31 Jul 75  E  01 Sep 95  10 Oct 95    D
02  BIEGLER,ANDREW           9 Aug 78  E  01 Sep 95  10 Oct 95    D
03  BIEGLER,BABY            08 Mar 97  E  19 Mar 97  22 May 97    D
20  BIEGLER,EDWARD J         4 Jul 53  D  09 Jun 97  07 Aug 97    D
30  BIEGLER,DIANE           16 Sep 55  E  09 Aug 97  26 Aug 97    D


,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Select (A)ll Family Members, (I)ndividual Family Members,
       or (Q)uit Family Disenroll: A//
```

Figure 5-54. Disenrollment Cancellation/Correction

The top Display Window displays the patient name, patient category, MCP status (must be Disenrolled), FMP, sponsor SSN, DDS number, and today's date.

The middle Select Window lists all family members associated to the same sponsor, along with the FMP, DOB, ACV, start and end dates, and current MCP status.

The bottom Interact Window contains an action bar with the following actions:

- **(A)ll Family Members -** Cancels a disenrollment or correct an enrollment end date for all family members associated to the same sponsor.
- **(I)ndividual Family Members -** Cancels a disenrollment or correct an enrollment end date for an individual family member.

– **(Q)uit Family Disenroll -** Exits the DCAN option without changing any disenrollment data.

1. Select (A)ll Family Members, (I)ndividual Family Members, or (Q)uit Family Disenroll: A//

   Enter I for (I)ndividual Family Members. A new action bar displays.

2. Select (D)isenrollment Cancellation, (C)orrect Disenrollment Date, or (Q)uit: D//

   Accept default (D)isenrollment Cancellation action. The Disenrollment Cancellation screen displays. Refer to Figure 5-55. Disenrollment Cancellation Screen, page 5-116. Note the status of D for Disenrolled.

```
                      DISENROLLMENT CANCELLATION
         Patient: BIEGLER,CAROLE                FMP/SSN: 01/534-48-2446
Patient Category: USAF FAM MBR RET                  DDS: 1
      MCP Status: DISENROLLED                       ate: 27 Aug 1997
-------------------------------------------------------------------------
  FMP  Family Member           DOB       ACV   Start       End    Status
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
   01  BIEGLER,CAROLE          31 Jul 75  E  01 Sep 95  10 Oct 95    D
   02  BIEGLER,ANDREW          29 Aug 78  E  01 Sep 95  10 Oct 95    D
   03  BIEGLER,BABY            08 Mar 97  E  19 Mar 97  22 May 97    D
   20  BIEGLER,EDWARD J        14 Jul 53  D  09 Jun 97  07 Aug 97    D
   30  BIEGLER,DIANE           06 Sep 55  E  09 Aug 97  26 Aug 97    D


,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Use SELECT key to select family member to CANCEL disenrollment
```

Figure 5-55. Disenrollment Cancellation Screen

1. Position the cursor beside the patient for whom you want to cancel the disenrollment and press <Select>.

   In the bottom Interact Window, the system replaces the *Use SELECT key to select family member to CANCEL disenrollment* prompt with the *OK to CANCEL the DISENROLLMENT for BIEGLER,CAROLE? Yes//* prompt.

2. OK to CANCEL the DISENROLLMENT FOR [PATIENT NAME]? Yes//

   Accept the “Yes” default. The *Enrollment End Date: [Enrollment End Date]//* prompt displays.

3. Enrollment End Date

   Enter a new Enrollment End Date (must be at least one day in the future). The *Reassign PCM [PCM name]? Yes//* prompt displays.

4. Reassign a PCM [PCM name]? Yes//

   Accept the "Yes" default.

   If you enter "N" for No, the *Select Reassign PCM* prompt displays. If you attempt to continue without either reassigning the patient's former PCM or assigning a new PCM, the following message displays:

   > If no PCM is assigned, unable to process disenrollment cancellation, and returns to the Disenrollment Cancellation screen.

   When you accept the "Yes" default, the *Do you wish to CANCEL the DISENROLLMENT? No//* prompt displays.

1. Do you wish to CANCEL the DISENROLLMENT? No//

   Enter "Y" to indicate you wish to cancel the disenrollment. A new action bar displays allowing you to process another family member or quit.

2. Press <Return> to accept the default (Q)uit action.

   The Disenrollment Cancellation/Correction screen redisplays. Refer to Figure 5-56. Disenrollment Cancellation/Correction Screen, New MCP Status, page 5-118. Notice that the patient's MCP status is now Invalid Enrollment in the top Display Window and IE for Invalid Enrollment in the middle Select Window.

```
                DISENROLLMENT CANCELLATION/CORRECTION
         Patient: BIEGLER,CAROLE                FMP/SSN: 01/534-48-2446
Patient Category: USAF FAM MBR RET                  DDS: 1
      MCP Status: INVALID ENROLLMENT              Date: 26 Aug 1997
-------------------------------------------------------------------------
FMP  Family Member          DOB       ACV  Start      End       Status
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
01  BIEGLER,CAROLE          31 Jul 75  E  01 Sep 95  10 Oct 95    IE
02  BIEGLER,ANDREW           9 Aug 78  E  01 Sep 95  10 Oct 95    D
03  BIEGLER,BABY            08 Mar 97  E  19 Mar 97  22 May 97    D
20  BIEGLER,EDWARD J         4 Jul 53  D  09 Jun 97  07 Aug 97    D
30  BIEGLER,DIANE           16 Sep 55  E  09 Aug 97  26 Aug 97    D



,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Select (A)ll Family Members, (I)ndividual Family Members,
       or (Q)uit Family Disenroll: Q//
```

Figure 5-56. Disenrollment Cancellation/Correction Screen, New MCP Status

Exit the option

Press <Return> at the next two action bars to exit the DCAN option

5.5 Reciprocal Disenrollment Processing (RENR)

Introduction

The Reciprocal Enrollment/Disenrollment functionalities allow you to reciprocally disenroll beneficiaries from a losing facility and optionally enroll them in MCP at your site.

- Reciprocal Disenrollment allows you to reciprocally disenroll a beneficiary from the losing facility without enrolling the beneficiary at your facility.
- Reciprocal Enrollment/Disenrollment allows you to enroll a patient at your facility while at the same time disenrolling the beneficiary from the losing facility. This is described in more detail in the next objective.

The Reciprocal Enrollment/Disenrollment functionality is accessible in the Enrollment option ONLY when a DEERS eligibility check is performed in realtime, not batched.

Reciprocal Disenrollment at the Losing Facility (Batch Process at Night) - DEERS maintains a separate file of all beneficiaries reciprocally disenrolled for each losing facility. DEERS automatically processes all of the beneficiaries who have been reciprocally disenrolled from any of their DMIS ID codes.

Once DEERS receives this request, it sends blocks (up to 55 records) of data to the requesting CHCS site. CHCS then begins automatically disenrolling those beneficiaries and removing them from their assigned PCMs. Once a block of data has been successfully processed, CHCS requests the next block, and so on until all data has been processed. CHCS then processes the data and verifies that the number of blocks received was correct. If correct, those blocks are purged from the DEERS database.

Examples of discrepancy responses for reciprocal disenrollments generated by CHCS and/or DEERS are:

- Data is not ready to be sent
- The transmission was not received
- There is no more data
- CHCS received more/fewer blocks than DEERS had sent
- The disenrollment was successful, but the enrollment was not.

A new cross-reference in the Patient file is used to locate the beneficiaries for auto disenrollment at the losing site.

If CHCS receives more/fewer blocks than DEERS has sent, Auto Disenrollment automatically starts over and requests the data again. If some blocks of data were already successfully processed, CHCS ignores the record if it encounters a beneficiary already disenrolled with the Remotely Disenrolled reason.

Those beneficiaries that CHCS has auto reciprocally disenrolled display on the Disenrollees for Period by Reason Report under the reason RD - Remotely Disenrolled. In the event any discrepancies are detected during the auto reciprocal disenrollment process, those beneficiaries display on the new Reciprocal Disenrollment Discrepancy Report. If a beneficiary CHCS identification has changed since enrollment, the beneficiary will not be disenrolled in CHCS. These discrepancies must be corrected by changing the patient back to the enrolling ID and disenrolling them.

When the automatically generated task is completed, it generates a bulletin informing the mail group that Auto Reciprocal Disenrollment has completed and it has encountered discrepancies to be resolved. If no discrepancies were encountered, the bulletin informs you which report to print for a list of all beneficiaries remotely disenrolled from the losing facility.

After confirming of a reciprocal disenrollment transaction, the following DEERS fields in the patient file are updated:

- ACV
- DMIS ID
- ACV Start Date
- ACV End Date
- PCM Location Code.

Reciprocal Disenrollment by Reason Roster - The Reciprocal Disenrollment by Reason Roster option is accessed from the Enrollment Rosters Menu (ROST). This report shows only reciprocal disenrollments issued by your site with the Disenrollment Reason Code of Reciprocally Enrolled/Disenrolled (RED) or Reciprocally Disenrolled (RD). You can select either one or both of the reciprocal disenrollment reasons that you wish to see on the report for a specified date range. This is a wide (132 column) report and may be output to line printers. These are disenrollments initiated by your facility to release enrollees from other facilities. This report does not list reciprocal disenrollments posted on your site from other sites.

> **Note:** The Disenrollees for Period by Reason Report allows you to print all of the other disenrollment reasons, including Remotely Disenrolled (RM).

Patients reciprocally disenrolled from your facility by another facility appear under “Remotely Disenrolled” (RM).

Reciprocal Disenrollment Discrepancy Report - The Reciprocal Disenrollment Discrepancy Report identifies the following discrepancies:

- Patient Not Enrolled at Losing Facility (usually occurs when patient identification information has changed)
- Patient Not Registered/Not Found at Losing Facility (usually occurs when patient identification information has changed).

This report must be printed within 14 days or it is automatically deleted. You should print the report so the discrepancies can be resolved. If discrepancies are not corrected, your site enrollment totals will not match DEERS totals.

> **Note:** You should print the Disenrollees for Period by Reason Report to list the beneficiaries that were remotely disenrolled. You can identify the disenrolling facility by doing a DEERS check and looking at the eligibility segments.

Reciprocal Enrollment/Disenrollment - Reciprocal Enrollment/Disenrollment processing is accessed through the Enrollment Enter/Edit option on the Enrollment Processing Menu. You must request a realtime DEERS eligibility check to initiate the function. Otherwise, CHCS does not know the beneficiary is enrolled elsewhere. When you begin an enrollment and DEERS indicates the beneficiary is already enrolled at another site, you can use this option to remotely disenroll the beneficiary from MCP at the losing facility, then enroll the beneficiary in MCP at your facility. The disenrollment is sent to DEERS and forwarded to the losing facility.

You may reciprocally enroll/disenroll an individual and/or family members.

Eligibility Requirements - Eligibility for the Reciprocal Enrollment/Disenrollment action requires the following:

- DEERS is running
- ACV from DEERS for the selected beneficiary is either A, TRICARE Prime (Active Duty); D, MEDICARE DEMONSTRATION; or E, TRICARE Prime (CHAMPUS).
- The beneficiary's DMIS ID code does not match any of the local facility's DMIS ID Codes
- The current date of this enrollment is after the ACV start date recorded on DEERS. DEERS does not store an end enrollment date, only a disenrollment date when posted.

Family Member screen - If a beneficiary is eligible for reciprocal enrollment/disenrollment, and you elect to proceed, you advance through the existing enrollment functionality. After you file the enrollment, CHCS sends a reciprocal enrollment/disenrollment transaction to DEERS. If you abort the enrollment, the reciprocal enrollment/disenrollment transaction is not sent and no changes are made. A reciprocal disenrollment can be entered on any CHCS host.

Family Members – If there is more than one family member enrolled at the losing facility, all the family members currently enrolled at that facility display on the Family Member screen. You may then select those family members you wish to process.

Currently Registered Family Members – If the family member is currently registered at the gaining facility, the name of the matching patient in CHCS displays and you are prompted to confirm that this is the correct patient to process.

Family Members Not Registered – If the family member is not currently registered at the gaining facility, you may register the family member immediately following the reciprocal enrollment/disenrollment prompt.

> **Note:** You enroll the initial beneficiary, then use the Family Enrollment option on the Demographics Display screen action bar to enroll the remaining family members. The system reciprocally enrolls/disenrolls those family members whom you had previously confirmed with a YES when the reciprocal enrollment/disenrollment prompt displayed on the Family Member screen.

You must confirm for each individual beneficiary/family member that you wish to proceed with disenrollment from the losing facility and proceed to enroll the beneficiary/family member in the gaining facility. Refer to Figure 5-57. Family Member Screen, page 5-122.

```
                          FAMILY MEMBER SCREEN
   Patient Name: BLITON,CALVIN                    FMP/SSN: 10/278-55-5025
            DOB: 01 Jan 1960
   Sponsor Name: BLITON,JERALD                Sponsor SSN: 278-55-5025
Elig Start Date: 09 Feb 1980                Elig End Date: INDEFINITE
-------------------------------------------------------------------------
Name             Sex   DOB         DDS  ACV  Dir  Med  DMIS ID Trans Date
_________________________________________________________________________

BLITON,JERALD    M     01Jan1960   20    A    E    N   0432    18Jul1997
BLITON,MARK      M     16Apr1982    1    N    N    N
BLITON,STEVEN    M     09Jun1986    2    N    N    N           21Sep1995
BLITON,MATTHEW   M     09Jan1990    3    N    N    N
BLITON,SAM       M     20Apr1997    4    E    E    N   0124    24Apr1997
BLITON,KATHRYN   F     09Apr1959   30    N    N    N
_________________________________________________________________________

BLITON,JERALD is this the patient you are disenrolling? Yes//
Do you wish to disenroll BLITON,JERALD from PORTSMOUTH USCG CLINIC (Y/N)?
```

Figure 5-57. Family Member Screen

Processing New Enrollment After Reciprocal Disenrollment

Enrollment Start Date – The system defaults 'today' in the Enrollment Start Date field for the gaining facility, however, you can edit this date using the following criteria:

- Must be on or after October 1, 1992
- Must be on or after the patient's date of birth
- Must not overlap a previous enrollment episode
- Must be at least one day after the Enrollment Start Date from the losing facility.

> **Note:** The disenrollment date for the losing facility is the gaining facility enrollment start date minus one day.

Enrollment End Date – The enrollment end date will be computed for the type of patient as follows:

- **Active-Duty** – For active-duty, the gaining facility Enrollment End Date becomes the Eligibility End Date from the registration/eligibility transaction received from DEERS. The user may override this date and enter any date.
- **Non-Active-Duty –** For non-active-duty, the Enrollment End Date defaults to one year from the Enrollment Start Date and is the last day of that month. The date can be edited to be any end-of-month date that is less than the system-defaulted Enrollment End Date.

Once you have filed the enrollment at the gaining facility and the enrollment/disenrollment transaction is sent to DEERS, you cannot edit the Enrollment Start Date. Ensure that the correct date has been entered. This prevents gaps in coverage and overlapping enrollment episodes that would result in invalid enrollments. You may only renew, disenroll, edit the Enrollment End Date, or cancel the new enrollment.

For those patients who have been successfully reciprocally disenrolled and enrolled, the system automatically inserts the following standard reciprocal enrollment comment into the Enrollment Comment field for the beneficiary at the gaining facility:

Transferred from [DMIS ID code description].

This flags the beneficiary as a transfer from another catchment area. If the DMIS ID code description is blank, then the DMIS ID code is printed.

> **Note:** When you cancel the reciprocal enrollment/disenrollment, the beneficiary/family member remains disenrolled at the losing site with the same effective date. You are only canceling the new enrollment at the gaining facility.

Batched DEERS Eligibility Requests - You must perform an online DEERS check, using the Enrollment option, to invoke the Reciprocal Enrollment/Disenrollment option in order to correct the discrepancy.

When the DEERS eligibility request is batched or if the DEERS link is not active when the enrollment action was performed, and the beneficiary is currently enrolled at another catchment area, DEERS issues a discrepancy when it receives the enrollment transaction. This results in the beneficiary's enrollment becoming an Invalid Enrollment (DEERS Discrepancy Code 56: Invalid Enrollment - Patient Already Enrolled) at the gaining facility. It is recommended that all enrollments be entered when the DEERS link is available to avoid discrepancies. Many beneficiaries and most active-duty are currently enrolled in TRICARE at another site so the probability is high that batched enrollments will be rejected.

If the DEERS link is down and enrollments cannot be processed, use the native DEERS (NDEERS) function to check the eligibility. Often, the DEERS link is up but the connection through CHCS is down. Return to the user sign-on and enter NDEERS as the username. This access requires special privileges. Contact the system administrator for assistance. If you connect to DEERS, then DEERS is up and the problem is with the link.

Once the discrepancy is encountered, the system identifies the beneficiaries with discrepancies and alerts you to print the Enrollment/Disenrollment Discrepancy Report to correct these beneficiaries. The CP Bulletin is now automatically scheduled through TaskMan.

New Disenrollment Reasons - The following disenrollment reasons are automatically inserted by CHCS in the Reciprocal Disenrollment History section of the MCP Patient file for the beneficiary at the losing and gaining facility:

- **RED (Reciprocally Enrolled/Disenrolled) -** Used when the gaining facility enrolls the beneficiary into their facility and disenrolls the beneficiary from the losing facility.

– **RD (Reciprocally Disenrolled)** - Used when the gaining facility disenrolls the beneficiary from the losing facility, then does not enroll the beneficiary at their facility.

– **RM (Remotely Disenrolled)** - Used at the losing facility when another facility not on their own CHCS host disenrolls the beneficiary.

RED and RD appear on the Reciprocal Disenrollment by Reason Roster.

RM appears on screens and reports and is counted like any other type of disenrollment.

Menu Path: PAS System Menu → M → EMCP → RENR

- **Security Keys**

  None identified

- **Required Fields**

  Patient name
  Sponsor name
  Disenrollment date

- **Application Description**

The Reciprocal Disenrollment Processing option allows you to reciprocally disenroll a beneficiary from MCP at the losing facility without enrolling this beneficiary in MCP at the gaining (local) facility.

– In order to perform a reciprocal disenrollment using this option, DEERS must be up and running. To be a candidate for reciprocal disenrollment, the beneficiary must be DEERS eligible, currently enrolled in MCP at another facility, registered in CHCS at the gaining facility, and associated with a DMIS ID code that does not match any of the local facility's DMIS ID codes. The beneficiary must also be assigned a TRICARE ACV in DEERS of A, TRICARE Prime (Active Duty); D, MEDICARE DEMONSTRATION; or E, TRICARE Prime (CHAMPUS).

Disenroll a Patient from Another Facility and do not enroll the patient in your facility

- **Data Entry Process**

Select the patient name

Confirm the location

Confirm the disenrollment date

Select the patient name

1. The patient name must already be registered at this facility to enable reciprocal disenrollment.
2. Confirm the patient name.
3. Confirm the sponsor name.

The system queries DEERS, then displays the Family Member screen. Refer to Figure 5-58. Family Member Screen, page 5-127. The screen displays the DMIS ID code of the facility where each beneficiary is currently enrolled in MCP.

You may select one or more family members for reciprocal disenrollment.

Note: DEERS must be running to enable reciprocal disenrollment. If DEERS is down, the message displays - 'DEERS must be running to process a Reciprocal Disenrollment. Please try again later.'

```
                              FAMILY MEMBER SCREEN
    Patient Name: POET,ZOE E                          FMP/SSN: 30/100-20-1601
              DOB: 16 May 1967
    Sponsor Name: POET,ZANE E                    Sponsor SSN: 100-20-1601
 Elig Start Date: 15 Mar 2001                 Elig End Date: 19 Mar 1993
--------------------------------------------------------------------------------
-
   Name                            Sex     DOB        DDS  ACV  Dir  Med  DMIS ID

   POET,ZANE E                      M   12 Sep 1965  20    A    E    N   0124
   POET,ZOE E                       F   16 May 1967  30    A    E    N   0124




POET,ZOE E is currently enrolled at NH PORTSMOUTH.
Do you wish to disenroll POET,ZOE E from NH PORTSMOUTH (Y/N)? Y

Disenrollment Date: 21 Jun 2001//
```

Figure 5-58. Family Member Screen

Confirm the location

1. Confirm the patient you are disenrolling and the location.

   Enter Y to reciprocally disenroll the patient from the losing facility.

Confirm the disenrollment date

1. Confirm the disenrollment date.

   Press <Return> to accept the default of today's date, or enter another date. The disenrollment date must be at least one day after the current enrollment episode start date at the losing facility.

   The system enters REMOTELY DISENROLLED as the disenrollment reason for the patient at the losing facility.

   You return to the Enrollment Processing Menu.

5.6 Conditional Enrollment Processing (CENR)

Menu Path: PAS System Menu → M → EMCP → CENR

- **Security Keys**

  None required.

- **Required Fields**

  Patient Name
  Division

- **Application Description**

The Conditional Enrollment Processing option enables you to check the eligibility of conditionally enrolled patients in DEERS, and to cancel their enrollments if they are not eligible. After conditional enrollments are filed, positive eligibility responses in any CHCS function automatically changes the status to "Enrolled." You can select individual patients, or all conditionally enrolled patients in one division, multiple divisions, or all divisions to initiate an eligibility check to DEERS to determine whether a newborn or new spouse has been enrolled and, if so, to update the CHCS status to "Enrolled."

If the patient is not enrolled in DEERS, CHCS automatically cancels the enrollment after 120 days.

- **Business Rules**

– Beneficiaries eligible for Conditional Enrollment status are Newborns (FMP 01 through 19 and less than one year old), not yet found on the DEERS system.

– The system performs automatic DEERS eligibility checks for beneficiaries with MCP Status of Conditional Enrolled for a period of 120 days after MCP Enroll Date in 7-day increments.

– If DEERS returns an Eligible response to the DEERS Eligibility Check within the 120-day Conditional Enrollment period, the MCP status of Conditional Enrolled will be changed to Enrolled the next time the CP Enrollment Bulletin runs. DEERS has already updated their database; therefore, no additional DEERS transactions are sent to DEERS.

– If DEERS does NOT return an Eligible response to the DEERS Eligibility Check, the MCP Status of Conditional Enrolled will be changed to Disenrolled on the 121st day following the MCP Enroll Date. This is one day past the 120-day conditional enrollment period. No additional DEERS Eligibility, Enrollment, or Disenrollment transactions will be sent to DEERS.

– The Direct Care field on the DEERS Eligibility screen is populated with the word, Eligible, when a beneficiary is found to be eligible.

Process a Conditional Enrollment Patient

- **Data Entry Process**

Select (I)ndividual Patient at the Conditional Enrollment Processing screen

Select the patient name

Complete the Conditional Enrollment DEERS Interactive Request screen

Select (I)ndividual Patient at the Conditional Enrollment Processing screen

Refer to Figure 5-59. Conditional Enrollment Processing, page 5-129.

```
                    CONDITIONAL ENROLLMENT PROCESSING

-------------------------------------------------------------------------------
-



-------------------------------------------------------------------------------
-
Select (I)ndividual Patient, (A)ll Patients, or (Q)uit: A//
```

Figure 5-59. Conditional Enrollment Processing

(I)ndividual Patient - Repeat an eligibility transaction for an individual patient with a conditional enrollment status. You may also cancel an individual's conditional enrollment. You may not cancel the real enrollment here if the beneficiary has been enrolled in DEERS. The system prompts you to begin by entering and confirming the name of a patient. The patient must be registered in CHCS and conditionally enrolled in MCP. The system performs

a MCP CHCS/DEERS Discrepant Data Check Function, and you proceed to the action bar described in the “Process Patients” section below.

(A)ll Patients - Search for all patients with a conditional enrollment status. You may search for all such patients from one, multiple, or all divisions. After the list of conditional enrollment patients displays, you may select one, several, or all patients to process. An action bar prompts you to select one, multiple, or all divisions, or to quit the action bar and return to the main action bar. If you enter a single division, the system prompts you to enter the name of a division, then continue to the action bar described in the section below. If you choose to select multiple divisions, a picklist of divisions displays, and you can select the divisions you want (or all divisions) from the list. The system then continues to the action bar to initiate conditional enrollment processing.

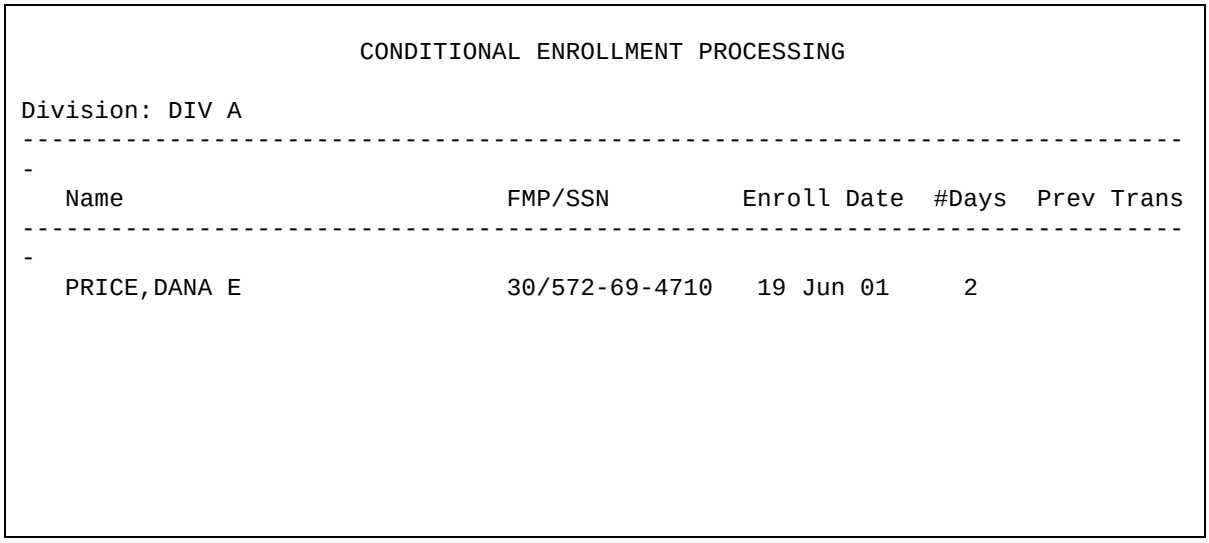
Select the patient name

1. Enter the name of the patient.

2. Confirm the patient name.

The Conditional Enrollment Processing screen displays. Refer to Figure 5-60. Conditional Enrollment Processing Screen, page 5-130. The patient name, with FMP/SSN, Enrollment Date, Number of Days Since Enrollment Initiated (#Days), and Previous Transaction Date (Prev Trans) displays in the middle Select Window.

All conditional enrollments display and an action bar allows you to repeat eligibility checks on patients you select.



```
--------------------------------------------------------------------------------
-
Select (R)epeat eligibility transaction, (C)ancel enrollment, or (Q)uit: Q//
```

Figure 5-60. Conditional Enrollment Processing Screen

1. Repeat the DEERS eligibility transaction on the patients.
2. Cancel the conditional enrollment of the patients.
3. Quit the action bar and return to the main action bar for individual patient or all patients, whichever was originally selected.

***(*R)epeat Eligibility Transaction** - Moves the cursor into the middle Select Window where you can select the patients for whom to perform a DEERS check. Refer to Figure 5-61. Conditional Enrollment Processing Screen, All Divisions, Repeat DEERS Check Action, page 5-131.

```
CONDITIONAL ENROLLMENT PROCESSING

Division: ALL DIVISIONS
--------------------------------------------------------------------------------
   Name                          FMP/SSN         Enroll Date  #Days  Prev Trans
_____________________________________________________________________________
__
   VALENCIA,ALBERT               05/999-11-2222   21 Jul 97   114    11 Nov 97
   ADAMS,RAYMOND                 30/112-12-1212   01 Aug 97   103    11 Nov 97
   BLITON,CATHERINE              09/278-55-5025   01 Aug 97   103    24 Oct 97
   BLITON,CHRISTINE              13/278-55-5025   23 Oct 97    20    28 Oct 97
   ROUSH,CAROLYN                 30/479-92-2665   01 Nov 97    11    11 Nov 97
   BRONSON,JUSTIN                12/278-55-5025   01 Nov 97    11    01 Nov 97




_____________________________________________________________________________
__
Use SELECT key to select patients to repeat eligibility transaction.
or use F9 key to view patient data.
```

Figure 5-61. Conditional Enrollment Processing Screen, All Divisions, Repeat DEERS Check Action

Note: If you position the cursor by a patient and press <F9>, the patient's conditional enrollment data displays, then you return to the patient selection process. For each selected patient, the system performs a DEERS check and prompts you to indicate whether to cancel the patient enrollment. As soon as the system has processed the last patient, it returns to the action bar. If the patient is enrolled in DEERS, the MCP status in CHCS is updated to "ENROLLED."

Enrollees of USTF Managed Care Program – Following the DEERS check, CHCS will search stored DEERS eligibility information to determine whether the patient is assigned an ACV code of "U" (Enrolled in USTF Managed Care). Refer to Section 3.1 Enrollment Processing, DEERS and Uniformed Services Treatment Facility (USTF) Enrollment, for further information.

(C)ancel Enrollment - Display a picklist to select the patients for whom to cancel the conditional enrollment. Indicate whether to cancel all the selected patients. If you choose yes, the system cancels enrollments in CHCS for all selected patients. In either case, the system returns you to the action bar described under "Process Patients" above.

1. Select the patient.

   Press <Select> at the patient's name, then press <Return>.The MCP - DEERS Post Eligibility Request screen displays.

2. Select the patient name.

3. Confirm the patient name.

   The DEERS Interactive Request screen displays. Refer to Figure 5-62. DEERS Interactive Request Screen, page 5-132.

```
DEERS ELIG/REG RESPONSES:                              DEERS INTERACTIVE REQUEST


                    Patient Name: PRICE,DANA E
                   Date of Birth: 28 Dec 1962
                     Sponsor SSN: 572694710
            Family Member Prefix: 30
          Eligibility Start Date:
            Eligibility End Date:


       When requesting information for a sponsor, enter 99 for the
         family member prefix to return all of the family members.

Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 5-62. DEERS Interactive Request Screen

Complete the Conditional Enrollment DEERS Interactive Request screen

1. Enter Patient Name.

2. Enter Date of Birth.

3. Enter Sponsor.

4. Enter Family Member Prefix.

5. Enter Eligibility Start Date.

   Enter the beginning date for which to check the patient's eligibility. This may be a past date if you want to perform a DEERS check to retrieve past eligibility data for this patient.

6. Enter Eligibility End Date.

   Enter the ending date for which to check the patient's eligibility. You may also enter a past date in this field.

7. File the data.

   A DEERS check is automatically processed. You may enter B to batch the DEERS check or Q to stop the DEERS request. If you enter Q, you may not continue with the conditional enrollment processing. When the DEERS response is received, the DEERS Eligibility Data screen displays with the patient eligibility fields updated.

   If the patient receives an ineligible status again, the *Do you want to CANCEL enrollment?* prompt displays. You can select to cancel this patient's enrollment at this time. For this example, the patient receives an eligible status.

8. Press <Return> until the Enrollment Processing Menu displays.

9. Exit the Enrollment Processing Menu.

   The Managed Care Program Menu displays.

5.7 Print/Display Enrollment History (PENR)

Menu Path: PAS System Menu → M → EMCP → PENR

- **Security Keys**

  None required.

- **Required Fields**

  Patient name
  Output device

- **Application Description**

The Print/Display Enrollment History option allows you to generate a list of the local enrollments on CHCS for a selected patient and display/print the enrollment history for any of those enrollments.

Print/Display an Enrollment History

- **Data Entry Process**

Select the patient name
Select (C)ontinue at the Demographics Display screen
Select (D)isplay/Print Enrollment History at the Enrollment History screen

Select the patient name

1. Enter the patient name.

   No DEERS check is performed. The patient must be registered in CHCS, but need not have a current or previous enrollment in MCP.

2. Confirm the patient name.

   The Demographics Display screen displays.

Select (C)ontinue at the Demographics Display screen

The Enrollment History screen displays. Refer to Figure 5-63. Enrollment History Screen, page 5-135. All enrollment episodes for the patient display in the middle Select Window. You may select one, several, or all episodes to print or display.

Print/Display Enrollment History – All enrollments for the current patient display, past and present, and an action bar prompts you to display/print the patient's enrollment history or to quit and exit the option.

If you display or print an enrollment history, the system prompts you to choose the enrollment(s) to display or print from a picklist. The system then displays or prints the enrollment report, and returns you to the action bar, where you can display/print another enrollment history, or quit and exit the option.

```
                              ENROLLMENT HISTORY
         Patient: PFEIFER,ALLISON E                  FMP/SSN: 20/572-69-4717
Patient Category: USAF ACTIVE-DUTY                       DDS:
    Patient Type: MCP/ACTIVE-DUTY                        Sex: FEMALE
      MCP Status: ENROLLED                          DOB/AGE: 25 Dec 1966/34Y
-------------------------------------------------------------------------------
-
   Enroll Date   Disenroll Date   Disenrollment Reason
-------------------------------------------------------------------------------
-
   16 Mar 01     10 Feb 03
   10 Jan 01     15 Mar 01        MOVING (OTHER)









-------------------------------------------------------------------------------
-
Select (D)isplay/Print Enrollment History, or (Q)uit: D//
```

Figure 5-63. Enrollment History Screen

Select (D)isplay/Print Enrollment History at the Enrollment History screen

The Display Enrollment History screen is divided into two parts. The top half displays the patient demographic data entered previously. The bottom half displays information about the patient's enrollment episode. The fields on this screen cannot be edited.

1. Select any enrollment episode.

The *Select DEVICE* prompt displays.

2. Select Device.

   If you press <Return>, the enrollment history displays on your screen. If you enter the name of a printer, the history prints on that printer.

3. Enter Right Margin.

   The Enrollment History displays or prints as shown below. Refer to Figure 5-64. Display Enrollment History Screen, page 5-136.

```
               Personal Data - Privacy Act of 1974 (PL 93-579)
                           DISPLAY ENROLLMENT HISTORY
                 Patient: PFEIFER,ALLISON E              FMP/SSN: 20/572-69-4717
     Patient Category: USAF ACTIVE-DUTY                      DDS:
         Patient Type: MCP/ACTIVE-DUTY                       Sex: FEMALE
           MCP Status: ENROLLED                          DOB/Age: 25 Dec 1966/34Y
=========================================================================
   Enrolling Division: DIV A
         Patient Type: MCP/ACTIVE-DUTY            Patient SSN: 572-69-4717
      MCP Enroll Date: 16 Mar 2001
 End Elig/Enroll Date: 10 Feb 2003
   Enrollment Comment:
                  ACV: A-TRICARE PRIME (ACTIVE-DUTY)
              DMIS ID:
             Language:
       ID Card Number: 4953430                    Date Issued: 20 Jun 2001
       Effective Date: 20 Jun 2001           Expiration Date: 10 Feb 2003

 Primary Care Manager: GREENE,JOHN M               PCM Phone: 202 271-5850
            Case Mgmt: YES
          Primary OHI:
      Enrolled Date:
          Enrolled By:

   Last Modified Date:
     Last Modified By:

   PCM Date of Change:    PCM Name:               PCM Changed By:

Press <RETURN> to continue
```

Figure 5-64. Display Enrollment History Screen

4. Press <Return> to exit the Display Enrollment History screen.

Exit the Enrollment History screen. The Enrollment Processing Menu displays.

5.8 Interactive DEERS Eligibility Request (IENR)

Menu Path: PAS System Menu → M → EMCP → IENR

- **Security Keys**

  None required.

- **Required Fields**

  Patient name
  FMP/SSN
  DOB
  Eligibility start date
  Eligibility end date
  Output device

- **Application Description**

The Interactive DEERS Eligibility Request option enables you to directly query DEERS to perform an eligibility check on a patient. To uniquely identify the patient, you must enter the patient name, DOB, sponsor SSN, and FMP. The system enables you to specify eligibility start and end dates to determine whether a patient who is currently ineligible in DEERS was eligible at an earlier date or will be eligible in the future. If you do not define a start and end date range, the system automatically defaults the start date of Jan 1 two years prior to the current date and the end date of six months into the future.

A patient does not have to be registered in CHCS to perform this option. If the patient is not registered in CHCS, the system prompts you to indicate whether to continue with the DEERS search or to quit the option. Note that the PCM does not display.

This option, unlike other options that perform DEERS checks, always queries DEERS directly. It does not use DEERS data stored in the Patient file by DEERS checks performed by other options within the past five days.

The DEERS Interactive Request screen displays, and prompts you to enter data essential for a DEERS query. If the patient is registered, the default values for patient name, DOB, FMP/SSN, and eligibility start and end dates are taken from CHCS.

<u>Perform a DEERS check on a patient</u>

- **Data Entry Process**

Select the patient name

Complete the DEERS Interactive Request screen

Display DEERS eligibility data

Select the (H)istorical DEERS action

Select the patient name

1. Enter the name of the patient whose eligibility is to be requested from DEERS.
2. Confirm the patient name.

   If the patient is not currently registered in CHCS, the *PATIENT NOT CURRENTLY REGISTERED. PROCEED WITH DEERS REQUEST?* prompt displays. You may enter "Yes" to continue with the DEERS request.

   For this example, the patient is already registered in CHCS, and the DEERS Interactive Request screen displays. Refer to Figure 5-65. DEERS Interactive Request Screen, page 5-139.

Complete the DEERS Interactive Request screen

```
DEERS ELIG/REG RESPONSES:                              DEERS INTERACTIVE REQUEST


                    Patient Name: PETERS,KENNETH K
                   Date of Birth: 22 Jan 1966
                     Sponsor SSN: 400407503
             Family Member Prefix: 20
          Eligibility Start Date: 01 Jan 1995
            Eligibility End Date: 27 Jan 1997


       When requesting information for a sponsor, enter 99 for the
         family member prefix to return all of the family members.
```

```
Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 5-65. DEERS Interactive Request Screen

1. Patient Name
2. Date of Birth
3. Sponsor SSN
4. Family Member Prefix
5. Eligibility Start Date.

   Enter the date to begin the eligibility check. This may be a past date if you want to perform a DEERS check to retrieve past eligibility data for this patient. The default date is two years in the past. Press <Return> to accept the default.

6. Eligibility End Date.

   Enter the date to end the eligibility check. For this example, enter T for today's date. You may also enter a past or future date in this field. The default date is six months in the future from today’s date. Press <Return> to accept the default.

7. File the data

A DEERS check is automatically processed. When the DEERS response is received, the DEERS Eligibility Data screen displays and the patient eligibility fields are updated.

Display DEERS eligibility data

As soon as you finish entering data into this screen, the system performs the DEERS search. If the specified sponsor SSN and DOB are found in DEERS, then CHCS displays the DEERS data on the DEERS Eligibility Data screen and permits you to print the eligibility data. Refer to Figure 5-66. DEERS Eligibility Data, page 5-140.

Enrollees of USTF Managed Care Program: Following the DEERS check, the system searches stored DEERS eligibility information to determine if the patient is assigned an ACV code of "U" (Enrolled in USTF Managed Care). Refer to Section 3.1 Enrollment Processing, DEERS and Uniformed Services Treatment Facility (USTF) Enrollment, for further information.

If the system fails to find a record with the specified sponsor SSN and DOB, it displays your search criteria on the DEERS Eligibility Data screen, and permits you to print the eligibility data.

If the system finds records with the specified sponsor SSN but not the specified DOB, then it displays a picklist of all family members with the same sponsor SSN, and prompts you to select the family member. That family member's DEERS data displays on the DEERS Eligibility Data screen, and you can print the eligibility data. The system then quits and exits the option.

```
                              DEERS ELIGIBILITY DATA
                 Name: PETERS,KENNETH K              FMP/SSN: 20/400-40-7503
     Patient Category: USN ACTIVE-DUTY                   DDS: 20
              DOB/Age: 22 Jan 1966/35Y                   Sex: MALE

                    NAME: PETERS,KENNETH K
                     SEX: MALE                                DOB: 22 Jan 1965
                     DDS: 20                         Sponsor SSN: 400-40-7503
                     ACV: A-TRICARE PRIME (ACTIVE-DUTY)
          ACV Start Date: 02 Oct 1992                Region Code: 02
                  DMIS ID: 0037-WALTER REED ARMY MEDICAL CENTER
  Care Authorization PH#:                          PCM Location: DIRECT CARE PC
            Sponsor Rank: LIEUTENANT JUNIOR GRADE
             Sponsor UIC: N31471-NAVPHIBASE
             Direct Care: ELIGIBLE                   Medicare: NOT ELIGIBLE
Dir Care Elig Start Date: 25 Sep 1998                 CHAMPUS: NOT ELIGIBLE
  Dir Care Elig End Date: 16 Mar 2004
  Eligibility End Reason: U-Not Predictable

                                      BRAC Pharmacy Eligibility:
                                 DOB Does NOT Match
Select to (V)iew more DEERS data, (H)istorical DEERS, (P)rint, or (Q)uit: Q//
```

Figure 5-66. DEERS Eligibility Data

> **Note:** The *DOB Does NOT Match* prompt displays in the middle Select Window when the patient's date of birth in CHCS and DEERS do not match. You should try to correct the inconsistency. Ask the patient for the correct date. If the CHCS data is incorrect, correct the DOB field on the Mini Registration screen. If the error is in the DEER system, instruct the patient to go to the nearest DEERS office and ask that this be corrected.

At the bottom of the DEERS Eligibility Data screen, available options on the action bar include:

(V)iew More DEERS Data - View additional data received from DEERS. If you select this option, an additional DEERS data screen displays for this patient. Information on this screen includes whether the patient is an organ donor, has any reportable diseases, and has CHAMPUS Dental care, the date this eligibility information was last updated, a Panograph date, and the date of the request.

(H)istorical DEERS - View historical DEERS eligibility data. If you select this option, the Historical DEERS Eligibility Data screen displays, listing up to 10 eligibility segments on file in DEERS for the selected date range.

(**O)verride Ineligibility -** This option appears on the action bar only if the Direct Care Eligibility code indicates Not Eligible, with a message stating “Patient Ineligible.” Enter an override code if the patient's Direct Care eligibility is Not Eligible. If you elect to override, you are then required to enter an override code to continue. Enter a question mark (?), to display a list of valid override codes.

(P)rint - Print all eligibility information, including the historical data, if available. If you select this option, the system prompts for a Device, then prints the report. The report includes information from the DEERS Eligibility Data screen, the additional DEERS Eligibility Data screen, as well as the Historical DEERS Eligibility Data screen. If you press <Return> in the Device field, the eligibility data will display on the screen rather than print.

(Q)uit - Exit the screen.

When eligibility data is not available and the site is operating in the DEERS Enrollment Mode, the site interprets eligibility based on the most recent enrollment transaction response from DEERS stored in CHCS. It is recommended that this function be executed with DEERS access to avoid confusion.

When the site is operating in local empanelment mode and eligibility is batch processed, the system will evaluate MCP status based on the eligibility response from DEERS. The time for the response from DEERS depends upon the number of eligibility requests in the queue and the system load.

Select the Historical DEERS action

The Historical DEERS Eligibility Data screen displays a listing of all previous eligibility segments and/or the last ten enrollment segments for the patient. You can request the default, which covers two years in the past and up to six months in the future. You can also enter a date range.

1. Press <Return> to continue.

   The DEERS Eligibility Data screen redisplays.

2. Quit the DEERS Eligibility Data screen.

5.9 Batch Enroll Active Duty (BENR)

Refer to Figure 5-67. Batch Enroll Active Duty (BENR) Menu, page 5-142, and Sections 5.9.1-4.

```
   IBER   Identify Potential Active Duty Candidates
   UBER   Update/Print/Enroll Potential AD Candidates
   PBER   Print Batch Enrollment Report
   DBER   Delete Potential Candidate List

Select Batch Enroll Active Duty Option:
```

Figure 5-67. Batch Enroll Active Duty (BENR) Menu

5.9.1 Identify Potential Active Duty Candidates (IBER)

Menu Path: PAS System Menu → M → EMCP → BENR → IBER

- **Security Keys**

  CPZ IDENTIFY AD

- **Required Fields**

  Medical activity date

- **Application Description**

The Identify Potential Active Duty Candidates option allows you to identify all active-duty records in the Patient file that have no MCP enrollment history. Based on the date of medical activity, records have flags to denote those active-duty candidates with medical activity since that requested date. When running this "identify" option, the system creates a potential active-duty enrollment candidate file that can then be used to update, print, and/or enroll the active-duty candidates.

At any time there is only one candidate file containing records of potential active-duty enrollment candidates. Rerunning this option deletes any previously created potential candidate file. The user should update those active-duty who are gone, separated, or ineligible with a permanent block flag so they are never selected again by this process. CHCS will remove the permanent block flag if the active-duty record is modified after the block flag is set.

Running this option will affect system performance, so schedule this option carefully. Eligibility checks will be put in the batch queue at night and daytime batched eligibility checks will not be performed until the batch enroll active-duty checks are completed.

Identify Potential Candidates

- **Data Entry Process**

You may select active-duty with medical activity after a selected date or process all active-duty ever registered in CHCS. Refer to Figure 5-68. Potential Active Duty Candidate Update/Report, page 5-143.

```
                POTENTIAL ACTIVE-DUTY CANDIDATE UPDATE/REPORT

Medical Activity Date: 22 Jun 1999
 Potential Candidates: 2858
-------------------------------------------------------------------------------
-



-------------------------------------------------------------------------------
-
Select candidates (W)ith Medical Activity, (A)ll Candidates, or (Q)uit: W//
```

Figure 5-68. Potential Active Duty Candidate Update/Report

The system prompts you to begin by issuing a warning message if a Potential Candidate file already exists, and requesting confirmation to purge the old file in order to create a new one. Refer to Figure 5-69. Identify Potential Active Duty Candidates Warning Message, page 5-144.

```
                IDENTIFY POTENTIAL ACTIVE-DUTY CANDIDATES


Medical Activity Date: 22 Jun 1999



                              WARNING !!!
    The Potential Candidates file already exists from 21 Jun 2001.
    If you continue with this action, the prior information will be
      deleted, along with any data updates that have been entered.



Are you sure you want to delete the Potential Candidate file? No//
```

Figure 5-69. Identify Potential Active Duty Candidates Warning Message

If you answer "No" and do not purge the old file, the system exits the option at this point. Refer to Figure 5-70. Identify Potential Active Duty Candidates Exit, page 5-144.

```
                IDENTIFY POTENTIAL ACTIVE-DUTY CANDIDATES


Medical Activity Date:
------------------------------------------------------------------------




          Enter a Medical Activity Date.  The system will identify all
          active-duty potential candidates who have not been enrolled
          previously.  The user will have the option to select only those
          records with medical activity since the activity date.


------------------------------------------------------------------------
Enter Date of Last Medical Activity: 22 Jun 1999//
```

Figure 5-70. Identify Potential Active Duty Candidates Exit

If you confirm to purge the old file, or if a previous file did not exist, enter a medical activity date (date of last medical activity). The system will again request confirmation to continue or to exit the option.

1. If a YES (to continue) is entered, the system prompts you to enter the date of last medical activity and tasks the job to build a Potential Active-Duty Candidate file.

Since the job is system intensive, it is processed at the hours designated in the File/Table Menu through the MCP Parameters Profile Enter/Edit option. This job may take several days to complete, and resumes building the file, where it left off the day before, at the designated task time each evening. This process continues until the file is completed. You receive a mail bulletin when the job has completed.

Refer to Section 2.4 File Table and Building and Maintenance, for information concerning mail bulletins. This section describes the menu path, business rules and specific bulletins associated with mail bulletins.

5.9.2 Update/Print/Enroll Potential AD Candidates (UBER)

Menu Path: PAS System Menu → M → EMCP → BENR → UBER

- **Security Keys**

  CPZ PCM AGR LOCK

- **Required Fields**

  UIC
  Patient category
  Alpha range
  SSN
  Enrollment date
  Output device
  Start/stop time

- **Application Description**

The Update/Print/Enroll Potential AD Candidates option allows you to update, print lists, or enroll potential active-duty candidates resulting from your previous use of the Identify Potential Active Duty Candidates option. You can select to process all candidates, or just candidates with medical activity. Processing should be performed in manageable subsets, and you can sort by UIC, patient category, alphabetically, or by SSN; then select a subset of the resulting selected data for processing convenience and manageability.

Update/Print/Enroll Potential AD Candidates

- **Data Entry Process**

Process only candidates with medical activity or process all candidates

Update data elements

Print report

Enrollment

Process only candidates with medical activity or process all candidates

The system displays the Potential Active Duty Candidate Update/Report screen. Refer to Figure 5-71. Potential Active Duty Candidate Update/Report, page 5-146.

```
                POTENTIAL ACTIVE-DUTY CANDIDATE UPDATE/REPORT

Medical Activity Date: 22 Jun 1999
 Potential Candidates: 2858




                                  WARNING!

          The Potential Active Duty Candidate List contains 2858
          entries.  You are strongly urged to update, display, or
          print subsets of the data.  Use the action bar below to
          create a subset appropriate to your needs.



Select to sort subset by (U)IC, (P)atient Category, (A)lphabet, (S)SN,
       or (Q)uit:U//
```

Figure 5-71. Potential Active Duty Candidate Update/Report

The action bar allows you to sort a subset of candidates by UIC, Patient Category, Alphabetically, or by SSN, or to quit and exit the option.

UIC Code Processing - When you elect to process by UIC, an action bar displays, allowing you to process one, multiple, or unknown UICs ("unknown" being a recognized category). If one is selected, the system prompts for the UIC code to process. If multiple is selected, the system prompts for a valid UIC code or partial description. This process is repeated until you press <Return> without making another entry. When that process is complete, or when "unknown" is selected, the system prompts for an alphabetic range of patient names to process (start and stop range). The system then continues with the Update/View, Print, and Enroll action.

Patient Category Processing - When you elect to process by patient category, the system prompts for the patient category code, then for an alphabetic start and stop range for the candidates within that patient category code.

Alphabet or SSN Processing - When you elect to process either alphabetically by candidate name or by social security number, the system then prompts for the start and stop range, which allows you to create a workable subset of the candidate file.

After establishing a working file, you can update, view, print lists, and/or enroll candidates from the working file. Press <F9> to view complete data about a candidate, and <F7> to search for a candidate. During the updating process you can select the Agreement Type for PCM assignment. Press <F9> to view location/preferences during this process, update the UIC and to assign the PCM and an alternate PCM when required. Refer to the Updating Section listed below for more information.

Upon completion of individual record updates, the system then redisplays the candidate list with all the individual records that have been updated low-lit and all remaining records highlighted.

Update data elements

The system allows you to select the data elements to be updated for the selected batch of candidates. These elements are UIC, PCM, Alternate PCM, and Enrollment Block Flag. You are also allowed to specify that the elements selected are used for all subsequent batches generated within the current session by selecting "Default Data Elements." Refer to Figure 5-72. Potential Active Duty Candidate Update/Report Data Elements Updates, page 5-148.

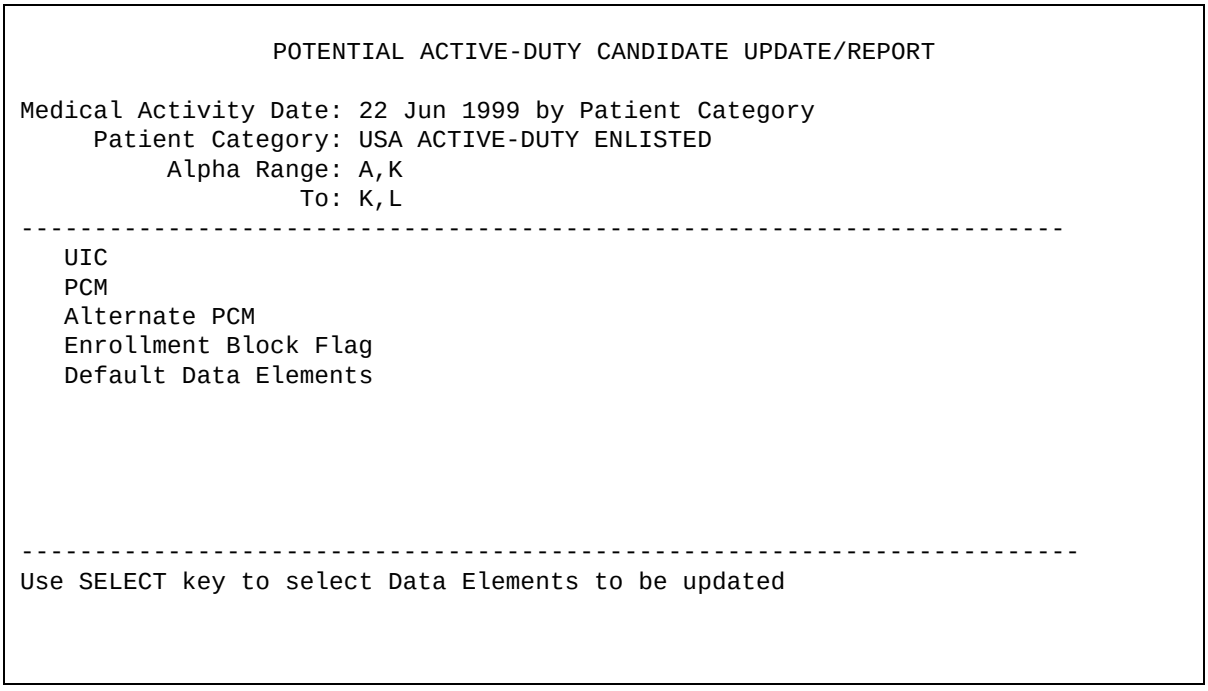


Figure 5-72. Potential Active Duty Candidate Update/Report Data Elements Updates

After selecting the data elements for update, the system prompts sequentially for UIC, PCM, Alternate PCM, and Enrollment Block Flag, depending upon the items selected.

Print report

When you want a report, the system prompts for the sections of the report to print. You may print a list of candidates eligible for enrollment, and/or a list of candidates not eligible for enrollment. Possible sorts for the report are: UIC, Patient Category, Alphabetical or by SSN. Section 2 (Candidates not eligible) is sorted by Enrollment Block Reason. Entries on the report are limited to those Potential Candidates selected as part of the subset.

Enrollment

Enrolling Division - The system enrolls candidates with the Enrolling Division set as the PCM’s place of care Division DMIS ID.

Enrollment Date - You can specify the date of enrollment for the batch of candidates being enrolled. The system establishes a default date of "tomorrow's date" which may be accepted by you as the enrollment date for the batch.

End Enrollment Date - The End Enrollment Date is the End Eligibility Date received from DEERS. Candidates without DEERS eligibility responses are not enrolled and are treated the same as candidates with any other Enrollment Block Reason.

The system tasks the enrollment process for the batch depending upon the values entered in the Hours for Running Batch Enrollment field and exits from the option. The system generates a notification bulletin to you when the task is completed.

Refer to Section 2.4 File Table and Building and Maintenance, for information concerning mail bulletins. This section describes the menu path, business rules and specific bulletins associated with mail bulletins.

5.9.3 Print Batch Enrollment Report (PBER)

Menu Path: PAS System Menu → M → EMCP → BENR → PBER

- **Security Keys**

  None required.

- **Required Fields**

  Spool document name
  Output device

- **Application Description**

The Print Batch Enrollment Report option allows you to print a two-part report showing successful active-duty enrollments and candidates unable to be enrolled. This report is printed from the document file previously created, edited, and processed through the batch enroll active-duty options (Identify Potential Active Duty Candidates option and Update/Print/Enroll Potential AD Candidates option).

The site prints this report to determine those enrollees who were selected during active-duty enrollment to be enrolled and the final status of their enrollment. Beneficiaries whose enrollments were rejected may be corrected and resubmitted.

- **Data Entry Process**

Proceed through the Managed Care Program Menu and Enrollment Processing Menu to the Batch Enroll Active Duty Menu and select the Print Batch Enrollment Report option. Refer to Figure 5-73. Print Batch Enrollment Report Screen, page 5-150.

```
Select SPOOL DOCUMENT NAME:CP BATCH UPD-21Jun01-1459-1
Number of Copies: 1//
Output to:
```

Figure 5-73. Print Batch Enrollment Report Screen

The system prompts for the spool document name, the number of copies you want, and the output device. The system then generates the two-part output report and exit the option.

5.9.4 Delete Potential Candidate List (DBER)

Menu Path: PAS System Menu → M → EMCP → BENR → DBER

- **Security Keys**

  CPZ IDENTIFY AD

- **Required Fields**

  None

- **Application Description**

The Delete Potential Candidate List option allows an authorized user to delete the Candidate file after all updating/enrolling actions have been completed. Once deleted, no further actions for the active-duty batch enrollment process can be taken until a new Candidate file is created through the Identify Potential Active Duty Candidates option.

- **Data Entry Process**

Proceed through the Managed Care Program Menu and Enrollment Processing Menu to the Batch Enroll Active Duty Menu and select the Delete Potential Candidate List option (DBER).

The system prompts you to begin by requesting confirmation that all candidates should be deleted. Refer to Figure 5-74. Delete Potential Active Duty Candidate List Screen, page 5-151. The system then prompts again for confirmation to proceed with the file deletion. After receiving two confirmations, the system deletes the Candidate file and exits the option.

```
Delete Potential Active Duty Candidates
---------------------------------------


There are currently 2858 potential candidates remaining in the
Candidate file. This option will delete all candidates for all
users. All batch enrollment jobs previously tasked but not yet
complete will also be deleted. Following deletion, the Identify
option must be re-run to re-initiate Batch Active Duty Enrollment.


Do you want to delete all candidates? No//
```

Figure 5-74. Delete Potential Active Duty Candidate List Screen

5.10 Multiple Batch Renewal and Disenrollment Functions (MENR)

Introduction

This menu allows you to identify candidates for renewal notification, perform Batch Renewal and Disenrollment processing, print batch renewal and disenrollment letters, print batch renewal/disenroll rosters, and generate individual notification letters and labels.

The Batch Renewal Process - DEERS currently transmits eligibility data to CHCS. The batch renewal action requires that a DEERS eligibility request transaction be batched to verify eligibility for each beneficiary to be renewed.

MCP sites notify beneficiaries that their enrollment eligibility is expected to expire and encourage participants to renew their enrollment prior to the expiration date. Renewal Notification letters are generated one to two months in advance for all beneficiaries expected to lose enrollment coverage if not renewed.

5.10.1 Identify Candidates For Renewal Letter (IMER)

Menu Path: PAS System Menu → M → EMCP → MENR → IMER

- **Security Keys**

  CPZ RENEW DIS BATCH

- **Required Fields**

  Division(s)
  End enrollment start date
  End enrollment stop date
  MCP office

- **Application Description**

This option allows you to generate a list of non-active-duty beneficiaries whose enrollments expire within a specified date range and who therefore require a Renewal Notification Letter. This letter serves as a reminder to the recipient of their enrollment expiration date and a chance to respond whether they wish to renew or disenroll. The text of the letter may be edited by the site and will be displayed for all divisions that generate this letter.

The search criteria for the list is based on division(s) and date range. The option prompts you to enter enrolling division(s) and to enter a date range based on the beneficiary's enrollment end date.

The system then creates a processing job to identify beneficiaries who meet the search criteria. An output file is created as a result. A spool file is created to print (and reprint if necessary) renewal notification letters.

The date range (based on enrollment end date) is site defined. Also, the site can limit the identification of beneficiaries based on enrolling division(s). The generation of Renewal Notification Letters applies only to non-active-duty beneficiaries.

If beneficiaries renew their enrollment, these patients will not be included in a future process to identify candidates for disenrollment because their enrollment end date will have been extended one year.

Batch enroll candidates who qualify for renewal

Data Entry Process

Access the IMER option

Select enrolling division(s):

- **One**
- **Multiple**
- **All**

Access the IMER option

Select enrolling division(s)

This screen allows the user to select sets of divisions to search for renewal candidates. Refer to Figure 5-75. Renewal Notification Letter Candidates Screen, page 5-153.

```
                    RENEWAL NOTIFICATION LETTER CANDIDATES

   Enrolling Division:
End Enroll Date Range:
--------------------------------------------------------------------------------
-



--------------------------------------------------------------------------------
--
Select (O)ne, (M)ultiple, (A)ll Enrolling Divisions or (Q)uit:
```

Figure 5-75. Renewal Notification Letter Candidates Screen

One

If you select One division, you must identify the division to be used in the search criteria. Since One division is the default value for this action bar, the name of the selected division will display in the follow-on screen header. The division you are currently logged into is automatically displayed.

Multiple

When you select Multiple divisions to be used in the search criteria, you can identify one division or all divisions. Because of limited space in the header, the number rather than the names of the divisions selected display.

When multiple divisions are selected, only those enrolling divisions to which you have access display, based on 'allowable divisions' defined in your User file. An enrolling division can be one of the divisions, but not necessarily all of the divisions. The division you are currently logged into is automatically displayed as the default division.

All

If you select All divisions, the system automatically selects all allowable enrolling divisions to be used in the search criteria. If All is selected, 'All Selected' displays in the screen header. Refer to Figure 5-76. Renewal Notification Letter Candidates Screen, page 5-154.

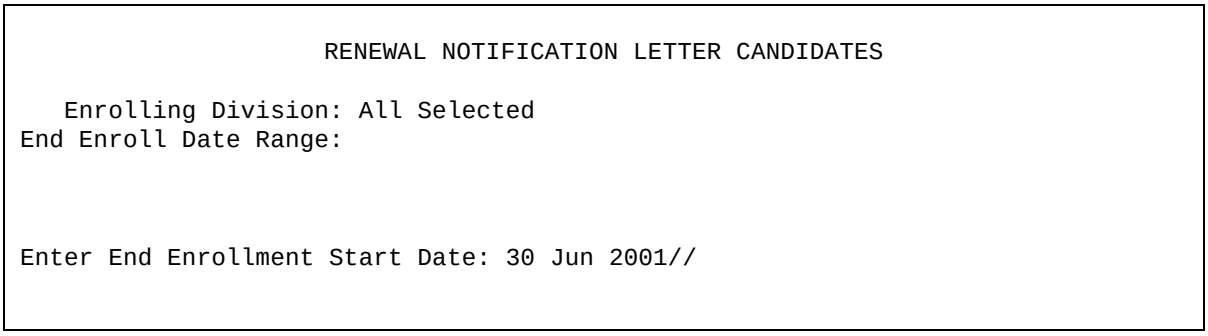


Figure 5-76. Renewal Notification Letter Candidates Screen

1. Enter End Enrollment Start Date.

   You can enter a question mark (?) to access help text to view other formats for entering the date. Enter the earliest enrollment end date that should be included when selecting enrollments for renewal letters.

   Notice that the default date for the earliest End Enrollment Date is the last day of the current month and the Stop Date is the last day of the following month. These dates will be used to select enrollments that will require renewal.

   You can define a date range of up to six months from the current date to search for expiring enrollments for non-active-duty beneficiaries.

2. Enter End Enrollment Stop Date.

   Enter the latest end enrollment date that should be included when selecting enrollment for renewal letters.

3. Select MCP Office.

   This address is used for the Renewal Notification Letters. When the users are HCFs, their associated MCP offices are defaulted.

4. Continue processing.

A message displays, indicating when the Renewal Notification Candidates file was last generated. The system also displays a task number and a message that you will receive a bulletin when the task is complete.

Refer to Section 2.4 File Table and Building and Maintenance, for information concerning mail bulletins. This section describes the menu path, business rules and specific bulletins associated with mail bulletins.

If you selected the option in error, you can enter No here and exit the option.

If you continue the process, the system informs you of the assigned task number for the letter batch job. Upon completion, the system forwards a mail message with the spool document name for the notification letters.

As a reminder, only non-active-duty beneficiaries are identified through this option.

5. Press <Return> to continue.

   The message 'Letters have been tasked.' displays.

6. Quit to exit the Renewal Notification Letter Candidates screen.

5.10.2 Batch Renewal and Disenrollment Processing (BMER)

Menu Path: PAS System Menu → M → EMCP → MENR → BMER

- **Security Keys**

  CPZ PCM AGR LOCK

- **Required Fields**

  Division
  Enrollment expiration date range
  Sponsor SSN

- **Application Description**

The Batch Renewal and Disenrollment Processing options allow you to identify candidates for renewal notification, perform Batch Renewal and Disenrollment processing, print batch renewal and disenrollment letters, print batch renewal/disenroll rosters, and generate individual notification letters and labels.

5.10.2.1 Batch Renew MCP Enrollments

- **Application Description**

The Renewal Batch Processing screen displays a candidate list based on the search criteria entered and the Renew action selected. Candidates for renewal must have a current MCP status of Enrolled.

If the candidate list is too large to be displayed in one screen, a plus sign (+) displays on the first and/or the last record in the window.

Beneficiaries displayed within this option are sorted by Sponsor SSN, then by FMP. The beneficiary name, FMP/SSN, PCM, DOB, and End Enrollment Date display.

- **Business Rules**

– The system provides the capability to allow assignment of PCMs from the contractor network with the agreement types of NET and SUP when batch renewing active-duty MCP enrollments.

Batch Renew MCP Enrollments

- **Data Entry Process**

Access the BMER option

Select enrolling division(s)

Select renewal date range

Select sponsor SSN(s)

Select patients to renew

Access the BMER option

The system prompts you to begin by displaying the initial action bar prompting you to either select One, Multiple, All enrolling divisions or quit and exit the option. Refer to Figure 5-77. Renewal & Disenrollment Processing Screen and Action Bar, page 5-157.

```
                    RENEWAL & DISENROLLMENT PROCESSING

Enrolling Division:
------------------------------------------------------------------------



------------------------------------------------------------------------
Select (O)ne, (M)ultiple, (A)ll Enrolling Divisions or (Q)uit:
```

Figure 5-77. Renewal & Disenrollment Processing Screen and Action Bar

Select enrolling division(s)

1. Enter O, M, or A to process one, multiple or all enrolling division(s).

   If you enter O for (O)ne Enrolling Division, the system replaces the action bar with this prompt:

   Select Enrolling Division: [default division] (OK)//.

   The default division is the division you are logged into. You can enter a different division name or accept the default. If you press <Return> to accept the default, you continue on to process only patients assigned to PCMs with the default division as their place of care. If you enter M for (M)ultiple Enrolling Divisions, the system adds a picklist of divisions to choose from in the middle Select Window.

2. Position the cursor beside a division you want to process and press <Select>, then <Return>.

Note: The Enrolling Division is the assigned PCM's place of care.

Select renewal date range

Search by sponsor SSN(s)

You may also search by sponsor SSN. If sponsor SSN is selected, you can enter one or multiple sponsor SSNs from which to search the database for batch renewal or disenrollment processing.

For a sponsor SSN search, you may enter one or multiple complete (9 digit) SSNs. As you enter the SSN, the entry displays in the middle Select Window along with the sponsor name. The system continues to prompt you to enter a sponsor SSN. If multiple SSNs are entered, the header is updated with the count of each one entered.

If you enter the search criteria of sponsor SSN, the (A)ll action is available.

If the (A)ll action is selected, the system automatically selects all patients for processing and you cannot remove or deselect any patients from the list. All records are then processed. All patients selected are renewed with the same PCM they are currently assigned to.

1. Enter End Enrollment Start Date

   Enter the earliest end enrollment date that should be included when selecting enrollments for renewal.

2. Enter End Enrollment Stop Date

   Enter the latest end enrollment date that should be included when selecting enrollments for renewal.

3. Select (R)enew Enrollment at the action bar.

When you select the (R)enew Enrollment action, all records display that meet the search criteria and are also non-active-duty beneficiaries. Refer to Figure 5-78. Renewal Batch Processing Screen, page 5-160.

If you select Disenroll, all records that meet the search criteria display. The disenrollment action is allowed for both active-duty and non-active-duty enrollees.

> **Note**: Be careful not to select disenroll for patients you wish to renew. This process cannot be reversed.

If you select Quit, the system returns you to the previous action bar.

> **Note:** The system automatically prevents patients from being assigned to a provider when the enrollment load is greater than the system capacity level.

Select patients to renew

```
                          RENEWAL BATCH PROCESSING

Enrolling Division: DIV A - TRAINING HOSPITAL
 End Enroll Search: 30 Jun 2001 to 31 Jul 2001
--------------------------------------------------------------------------------
-
   Patient Name           FMP/SSN         PCM                 DOB      End Enr

   PRESCOTT,ALBERT A      20/100-24-0024  FAM MED MTF         11Mar45  15Jul01
   PRESCOTT,BRENT B       20/100-24-0025  FAM MED MTF         05Jan52  15Jul01
   PRESCOTT,CURT C        20/100-24-0026  FAM MED MTF         08Jul56  15Jul01
   PRESCOTT,DONALD D      20/100-24-0027  FAM MED MTF         21Jun45  15Jul01
   PRESCOTT,EDMUND M      20/100-24-0028  FAM MED MTF         21Aug50  15Jul01
   PRESCOTT,FRANCIS F     20/100-24-0029  FAM MED MTF         01Jul55  15Jul01
   PRESCOTT,GERALD G      20/100-24-0030  FAM MED MTF         03May45

--------------------------------------------------------------------------------
-
Select ONE Renewal PCM for (M)ultiple patients, (I)ndividual patient,
       or (Q)uit:
```

Figure 5-78. Renewal Batch Processing Screen

If you select the (M)ultiple action, the system positions the cursor in the middle Select Window and allows you to select patients for processing. The PCM will not be changed by the renewal.

If you select the (I)ndividual, the system positions the cursor in the middle Select Window and allows you to select patients for processing. After each beneficiary has been selected, the system prompts you to enter a Renewal PCM for that patient. After you have entered the Renewal PCM, the cursor returns to the patient list and allows you to continue to select another patient to individually process. The enrolling division will be the DMIS ID of the PCM place of care.

1. Select the candidates to be updated.

   Position the cursor next to each of the specified names and press <Select>. Press <Return> to activate your selections.

2. Once you have selected a candidate, you may press <F9> to view current enrollment information.

3. In addition to viewing beneficiary information within the candidate list, you may press <F7> to search for a particular record within the list. This feature lets you navigate quickly through the candidate list. Using this key, you can enter a string of numeric characters (three to nine digits) to search for a sponsor SSN.

4. Select Prior PCM?

   The beneficiary has the option to continue with their current PCM. If the user answers “No”, a new PCM may be selected.

> **Note:** Beginning with CHCS Version 4.6, users with the security key, CPZ PCM AGR LOCK, can assign active-duty beneficiaries to network PCMs with the agreement types of NET or SUP, in addition to direct care providers with agreement types of MTF and CON.
>
> Only PCMs with available capacity are listed.

5. The list of candidates displays again. This allows you to select additional candidates, if you need to do so.

   Do not select additional candidates.

6. Select (P)rocess batch on the action bar.

7. Continue and (R)enew the batch.

   A message displays that the Batch Renewal process has been tasked. Also, the task number is identified, and the notice displays that you will receive a bulletin when the process is complete.

Refer to Section 2.4 File Table and Building and Maintenance, for information concerning mail bulletins. This section describes the menu path, business rules and specific bulletins associated with mail bulletins.

8. Quit to exit the Renewal Batch Processing screen.

5.10.2.2 Batch Disenroll Candidates

- **Application Description**

The Batch Disenrollment Process - Batch disenrollment requires that a disenrollment transaction be sent to DEERS when the site is operating in DEERS enrollment mode for non-active-duty enrollees and for active-duty enrollees. In empanelment mode, transactions go to DEERS for active-duty and TRICARE Senior only.

Once candidates who have pending enrollment expiration dates have been identified, they are informed and given the opportunity to renew or disenroll.

If a beneficiary has responded that they wish to disenroll, they are batch disenrolled and a Disenrollment Notification Letter is generated and sent to the family. Multiple family members are included on the family letter.

Enrollees are selected by division and by SSN or expiration date. The disenrollment date and reason are entered and can be applied either on an individual basis or to all candidates collectively.

The Disenroll Batch Processing screen displays a list of all records which meet the search criteria. The disenrollment action is allowed for both active-duty and non-active-duty enrollees.

Beneficiaries displayed within this option are sorted by sponsor SSN, then by FMP. The beneficiary name, FMP/SSN, DOB, End Enrollment Date, and PCM display.

If the candidate list is large, the screen displays a plus sign (+) to indicate that additional names are available on continuing screens.

Batch Disenroll Candidates

- **Data Entry Process**

Select division(s)

Select (E)nd Enrollment Date Range or (S)ponsor SSN

Select candidates to disenroll

Enter disenrollment data

Select division(s)

The user may select any enrolling divisions to search provided the user is authorized access to the division. Refer to Figure 5-79. Renewal & Disenrollment Processing Screen 1, page 5-163.

```
                        RENEWAL & DISENROLLMENT PROCESSING

Enrolling Division:
--------------------------------------------------------------------------------




--------------------------------------------------------------------------------
Select (O)ne, (M)ultiple, (A)ll Enrolling Divisions or (Q)uit:
```

Figure 5-79. Renewal & Disenrollment Processing Screen 1

Refer to Figure 5-77. Renewal & Disenrollment Processing Screen and Action Bar, page 5-157, for a description of this screen's functions.

Select (E)nd Enrollment Date Range or (S)ponsor SSN

Enter selection criteria that will be used to select enrollees to disenroll. Refer to Figure 5-80. Renewal & Disenrollment Processing Screen 2, page 5-164.

```
                    RENEWAL & DISENROLLMENT PROCESSING

Enrolling Division: DIV A - TRAINING HOSPITAL
------------------------------------------------------------------------------









------------------------------------------------------------------------------
Select (E)nd Enrollment Date Range, (S)ponsor SSN, or (Q)uit:
```

Figure 5-80. Renewal & Disenrollment Processing Screen 2

1. Enter E for (E)nd Enrollment Date Range.

Refer to Figure 5-81. Renewal & Disenrollment Processing Screen 3, page 5-164.

```
                RENEWAL & DISENROLLMENT PROCESSING

Enrolling Division: DIV A - TRAINING HOSPITAL
 End Enroll Search:



Enter End Enrollment Start Date: 30 Jun 2001//
```

Figure 5-81. Renewal & Disenrollment Processing Screen 3

Select candidates to disenroll

Candidates may be selected according to the date their enrollment will expire. Their expiration dates must be future dates. Candidates may also be selected by one or multiple SSNs. Refer to Figure 5-82. Disenroll Individual, page 5-165, for single SSNs. Refer to Figure 5-83. Disenroll Batch, page 5-166, for multiple SSNs.

```
                    RENEWAL & DISENROLLMENT PROCESSING

Enrolling Division: DIV A - TRAINING HOSPITAL
Sponsor SSN Search:
------------------------------------------------------------------------
Sponsor SSN     Sponsor Name

  569-69-4415    PEARL,ZACHARY N
              <----- Enter Sponsor SSN




------------------------------------------------------------------------
Enter a valid Sponsor SSN.
A maximum of 100 is allowed.
```

Figure 5-82. Disenroll Individual

1. Enter SSNs one at a time.

   When Sponsor SSN is selected, you can enter one or multiple Sponsor SSNs from which to search the database for batch renewal or disenrollment processing.

   You can enter up to 100 complete (9 digit) SSNs for the search.

   The SSN displays in the middle Select Window as you enter it, along with the Sponsor name. If you enter multiple Sponsor SSNs, the header is updated with the number of entries.

2. Press <Return> to exit the prompt.

3. Press <Select> to select beneficiaries.

4. Select the (D)isenroll action at the action bar.

   Potential candidates for disenrollment must have a current MCP status of Enrolled.

Note that enrollment loads may exceed the acceptable system capacity. However, the patient load is reduced as patients are disenrolled and the loads may be lowered back to capacity level. After reaching capacity, they are no longer permitted to exceed capacity.

```
                        DISENROLL BATCH PROCESSING

Enrolling Division:  All Selected
 End Enroll Search:  05 May 1997 to 13 Jul 1997
-------------------------------------------------------------------------
  Patient Name    FMP/SSN         PCM              DOB      End Enr
-------------------------------------------------------------------------
  ALLEN,GLORIA E  30/239-21-3116  GRAAM,GOSLING    05May55  31May97
  MANUEL,PATRICK  01/450-13-7095  MIAMI LAKES MEDI 11Oct93  31May97
  MANUEL,MARIA    30/450-13-7095  MIAMI LAKES MEDI 07Jun67  31May97
  CLARK,KAREN     30/453-82-7466  JOHNSON,DAVID    31Jan50  31May97
  STEWART,RENATE  30/457-76-9605  ALEXANDER,NICK   22Sep48  31May97
  MORRISEY,DANIEL 20/482-52-3205  HARTFORD,MEDICAL 31Mar44  31May97

-------------------------------------------------------------------------
Select ONE Disenrollment Date/Reason for (M)ultiple patients,
    (I)ndividual patient, or (Q)uit:
```

Figure 5-83. Disenroll Batch

1. Select Multiple patients or individual patients.

   You can position the cursor at an individual candidate name or multiple candidate names, then press <F9> to view current enrollment information.

Enter disenrollment data

1. Enter Disenrollment Reason.

   A list of reasons for disenrollment displays. You must select a reason from the list. This reason will be assigned to all selected disenrollees.

   The list has standard entries but also allows site definable entries.

   If you select Multiple patients, this Disenrollment Reason applies to all patients that were selected be disenrolled. If you select an individual patient, the Disenrollment Reason entered here, applies only to that patient.

2. Accept the default Disenrollment Date.

   If you selected Multiple patients, this Disenrollment Date applies to all patients that were selected to be disenrolled. If you selected an individual patient, the Disenrollment Date applies only to that patient.

The existing nightly tasked job (CP Enrollment Bulletin) transmits a DEERS disenrollment transaction on the day in which the disenrollment date occurs if it is a future date. A patient retains the enrollment status of Enrollee in DEERS until the disenrollment date is in the past.

For sites operating in DEERS Enrollment mode, a disenrollment transaction is sent for all beneficiaries. For sites operating in local empanelment mode, a disenrollment transaction is sent only for active-duty and Medicare beneficiaries (who are not affected by the mode indicator).

3. Process this batch.

   The message displays the number of records that will be batch disenrolled.

4. Continue to disenroll this batch.

5. Enter the MCP Office.

   After the MCP Office has been entered, the message displays that Batch Disenrollment process has been tasked, along with the task number. You will receive a bulletin when complete.

6. Press <Return> to continue.

   Once the batch disenroll process has been completed, the system returns you to the action bar to repeat the disenroll batch processing for additional patients, if necessary.

7. Select Quit to exit the screen.

   You are returned to the Multiple Batch Renewal and Disenrollment Functions Menu.

5.10.3 Print Batch Renewal & Disenrollment Products (PMER)

Menu Path: PAS System Menu → M → EMCP → MENR → PMER

- **Application Description**

The Print Batch Renewal & Disenrollment Products option has three subsets: Letters, Labels, and Roster. When you select PMER, you will see a screen that allows you to choose one of the three. Refer to Figure 5-84. Print Batch Renewal & Disenrollment Products Options, page 5-168. Each is described separately below.

```
 1      Batch Renew & Disenroll Letter

 2      Batch Renew & Disenroll Labels

 3      Batch Renew & Disenroll Roster

Select Print Batch Renewal & Disenrollment Products Option:
```

Figure 5-84. Print Batch Renewal & Disenrollment Products Options

5.10.3.1 Batch Renew & Disenroll Letter

Menu Path: PAS System Menu → M → EMCP → MENR → PMER → 1

- **Application Description**

The Batch Renew & Disenroll Letters option allows you to print renewal and disenrollment letters in batch form to be mailed to beneficiaries from spool files previously generated via the following options:

Identify Candidates for Renewal Notification Letter
Batch Renewal & Disenrollment Processing.

This option additionally generates an Incomplete Patient Address Report, listing beneficiaries in the spool file batch who had insufficient address information for generation of the renewal or disenrollment letter.

The Renewal Notification Letter - The Renewal Notification Letter is generated only for non-active-duty beneficiaries. Only one Renewal Notification letter is printed for family members who have the same enrollment expiration date, Sponsor SSN, and mailing ZIP code when contained in the same processing batch. The site may change the text of the letter.

For family members who have the same end enrollment date, this date is printed at the bottom of the Notification Letters. The beneficiary's home address is used as the mailing address for the Notification Letter and mailing labels.

Refer to Section 5.10.1 Identify Candidates For Renewal Letter (IMER), page 5-151, for more information.

The Disenrollment Notification Letter - Disenrollment Notification Letters are generated for non-active-duty and active-duty beneficiaries. Only one Disenrollment Letter is printed

for family members who have the same disenrollment date, Sponsor SSN, and mailing ZIP code if contained in the same processing batch. The site may change the text of the letter, though the signature line on the letter is automatically generated based on the user who is logged onto the system and cannot be changed.

For family members who have the same disenrollment date, only one letter is printed and the date is printed at the bottom of the letter. The beneficiary's home address is used as the mailing address for the Notification Letter and mailing labels.

For family members identified in the same renewal job, letters and labels are printed in the following FMP order: 30, 01, 02, 03, 04, etc. Letters and labels are tasked to be printed during off peak hours.

Batch Renew & Disenroll Letters

- **Data Entry Process**

Select spool document name

Specify the number of copies of each letter to print

Enter the output device

Select spool document name

This name identifies the candidates for renewal or disenrollment.

Specify the number of copies of each letter to print

Enter the output device

The Renewal Notification Letters scroll on the screen. Refer to Figure 5-85. Sample Renewal Notification Letter, page 5-170.

```
OFFICE OF HEALTH CARE FINDER

678 DUPONT CIRCLE

WASHINGTON, DC 20308

TRICARE PRIME RENEWAL NOTIFICATION LETTER

June 21, 2001

ALBERT A PRESCOTT

3278 HALL STREET

LANHAM, MD 20703

Dear ALBERT A PRESCOTT,

Your current enrollment and the enrollment of any family members listed below
will expire on the end enrollment date indicated. If you wish to renew your
enrollment, the appropriate enrollment form and renewal fee (if applicable)
must be received at the Tricare Service Center by the 20th of the month before
your enrollment expires.

If you do not elect to renew your enrollment, you will be disenrolled effective
the first day after your enrollment expires. Your benefit entitlement will
revert to prior entitlement. You will no longer be assigned to your current
Primary Care Manager and you will receive medical services only on a space
available basis in our military treatment facilities.

If you have any questions or concerns, you may call the TRICARE SERVICE CENTER
at (307) 555-2933.

      Sincerely,

      OFFICE OF HEALTH CARE FINDER

      WANDA JONES, Health Care Finder
```

Figure 5-85. Sample Renewal Notification Letter

5.10.3.2 Batch Renew & Disenroll Labels

Menu Path: PAS System Menu → M → EMCP → MENR → PMER → 2

- **Application Description**

The Batch Renew & Disenroll Labels option allows you to print renewal and disenrollment labels in batch form from spool files previously generated via the following options:

Batch Renewal & Disenrollment Processing
Identify Candidates for Renewal Notification Letter.

Batch Renew & Disenroll Labels

- **Data Entry Process**

Select user(s) or label print job

Select the users who requested the labels

Print labels

Select user(s) or label print job

Search for labels generated by one user, all users, or the print task number at the Batch Renewal & Disenrollment Labels screen. Refer to Figure 5-86. Batch Renewal & Disenrollment Labels Screen, page 5-171.

```
                    BATCH RENEWAL & DISENROLLMENT LABELS

                                          Total   # Labels
    Task #  User                          Found   To Print    Date Generated
-------------------------------------------------------------------------------




-------------------------------------------------------------------------------
Search for labels generated by (T)ask #, (O)ne user, (A)ll users or (Q)uit:
```

Figure 5-86. Batch Renewal & Disenrollment Labels Screen

1. If you select the (T)ask number action, the system allows you to search for the spool file by task number.

2. If you select the (O)ne user action, the system allows you to search for spool files created by one person by prompting you to *Select USER*. After you enter a user

name, the name and task number display and you are prompted to select the label batch. Refer to Figure 5-87. Batch Renewal & Disenrollment Labels, page 5-172.

3. If you select the (A)ll users action, the system allows you to search for spool files created by any user and presents you with a list of files. The system allows you to select the spool file you want from the list.

> Note: If you specify a spool file that does not contain any labels for printing, then the following message displays: `THERE ARE NO LABELS ELIGIBLE FOR PRINTING` , then the Spool File Selection action bar redisplays.

4. If you select the (Q)uit action, the system exits the option.

Select the user(s) who requested the labels

```
                    BATCH RENEWAL & DISENROLLMENT LABELS

                                        Total   # Labels
    Task # User                         Found   To Print    Date Generated
-------------------------------------------------------------------------------
--

      1030 SMITH,FRANK                  10      10          20 Jun 2001@1902


-------------------------------------------------------------------------------
--
Use the SELECT key to select label batch
```

Figure 5-87. Batch Renewal & Disenrollment Labels

1. With the cursor beside the user name, press <Select>.

   The system replaces the *Use the SELECT key to select label batch* prompt with an action bar. Refer to Figure 5-88. Batch Renewal & Disenrollment Labels Screen, page 5-173.

```
                    BATCH RENEWAL & DISENROLLMENT LABELS

                                        Total   # Labels
    Task # User                         Found   To Print    Date Generated
-------------------------------------------------------------------------------
--

      1030 SMITH,FRANK                  10      10          20 Jun 2001@1902


-------------------------------------------------------------------------------
--
Select (P)rint, (D)elete batch, (V)iew search Criteria or (Q)uit:  P//
```

Figure 5-88. Batch Renewal & Disenrollment Labels Screen

1. If you select the (P)rint action, a warning displays, stating that large print orders may cause a printer jam and the number of labels that are waiting to print. Refer to Figure 5-89. Batch Renewal & Disenrollment Labels Screen, page 5-174.

   The system also displays another action bar containing the following actions: (S)UBSET, (A)LL LABELS, (T)EST PRINTER, and (Q)UIT. Refer to the Print Action Bar paragraphs later in this section.

2. If you select the (D)elete batch action, the system prompts you to confirm that you want to delete the spool file. If you respond NO, the system redisplays the Print/Delete/View action bar. If you respond YES, the system deletes the spool file and redisplays the Spool File Selection action bar.

3. If you select (V)iew search criteria action, data about the spool file displays, such as name of the user who created the file, the date the file was created, the action (renewal or disenrollment), the enrolling divisions, and the end enrollment start and stop date range.

4. If you select the (Q)uit action, the Spool File Selection action bar redisplays.

```
                    BATCH RENEWAL & DISENROLLMENT LABELS

                                Total       # Labels
   User                         Found       To Print           Date Generated
--------------------------------------------------------------------------------
-
   SMITH,FRANK                  10          10                 20 Jun
2001@1902


              CAUTION:  LARGE PRINT ORDERS WILL INCREASE THE RISK
                                OF A PRINTER JAM!

                There are currently 10 labels waiting to print.




--------------------------------------------------------------------------------
--
Select to print a (S)ubset, (A)ll Labels, (T)est printer, or (Q)uit: A//
```

Figure 5-89. Batch Renewal & Disenrollment Labels Screen

Print labels

1. If you select the (S)ubset action, the system prompts you to enter the number of labels to print. The system allows you to enter a minimum of one and a maximum equal to the number of labels in the spool file. After you specify a number, the system prompts you to specify an output device. The system will then generate the output and redisplay the Spool File Selection action bar.

Note: If there is only one label in the batch, the system will suppress the (S)ubset action.

   If you select the (A)ll labels action, the system prompts you to specify the output device. The system will generate the output and redisplay the Spool File Selection action bar.

   If you select the (T)est printer action, the system prompts you to specify the output device and will print test labels on that device. The system will then redisplay the Print action bar.

If you select the (Q)uit action, the system will redisplay the Print/Delete/View action bar. Refer to the Print/Delete/View Action Bar paragraphs earlier in this section.

2. Select Device.

3. Select Quit at the action bar to exit the Batch Renewal & Disenrollment Labels screen.

5.10.3.3 Batch Renew & Disenroll Roster

Menu Path: PAS System Menu → M → EMCP → MENR → PMER → 3

- **Application Description**

The Batch Renew & Disenroll Roster option allows you to print a roster listing beneficiaries previously identified either for renewal or for disenrollment via the Batch Renewal & Disenrollment Processing option.

Print Batch Renew & Disenroll Roster

- **Data Entry Process**

1. Select Spool Document Name.

   This name identifies the candidates for renewal or disenrollment.

2. Specify the number of copies to print.

3. Enter the output device.

   The Roster scrolls on the screen if you press <Return> at the Device prompt.

5.10.4 Generate Individual Notification Letter & Label (GMER)

Menu Path: PAS System Menu → M → EMCP → MENR → GMER

- **Application Description**

The Generate Individual Notification Letter & Label option allows you to generate individual renewal or disenrollment notification letters and labels for a single beneficiary.

If the patient is active-duty, the system prompts you to quit, if renewal letters are requested. If the patient is disenrolled, then the system allows you to print a disenrollment notification or to quit. If the patient is enrolled, you may print a renewal notification or quit. If you choose to quit, the system will remove all patient data from the screen and prompt you to enter a patient name.

If you elect to print a renewal or a disenrollment notification, enter the name of the MCP office that will be printed on the letter as the return address. If you are entered into the database as an HCF, the system enters your associated MCP office as the default. You will then enter the name of the device on which the letters are to be printed.

After you select an output device, the letter will print and the system will allow you to print an address label. If you choose not to print an address label, you will return to the initial Generate Individual Notification Letters/Labels screen and can select another patient or exit the option. If you decide to print an address label, the system prompts you to enter the name of the output device. Once you specify the device, you will return to the initial Generate Individual Notification Letters/Labels screen and be able to either select another patient or exit the option.

Generate an Individual Notification Letter & Label

- **Data Entry Process**

Select the patient
Select Disenrollment or Renewal Notice to print
Select MCP office
Print an address label for the letter

Select the patient

1. Enter the name of the patient for whom to print the notice.
2. Confirm the patient name.

The Generate Individual Notification Letters/Labels screen displays, showing data about the patient. Refer to Figure 5-90. Generate Individual Notification Letters/Labels Screen, page 5-177.

If the patient is disenrolled, the Disenrollment Notification action displays. If the patient's enrollment has been renewed, the Renewal Notification action displays.

Select Disenrollment or Renewal Notice to print

```
              GENERATE INDIVIDUAL NOTIFICATION LETTERS/LABELS

       Patient Name: PEARL,JOE N
 Enrolling Division: DIV A - TRAINING HOSPITAL
  Start Enroll Date: 20 Jun 2001
    End Enroll Date: 20 Jun 2001
   Disenroll Reason: ENROLLMENT CANCELED
Last Renewal Letter:




Print (D)isenrollment Notification, or (Q)uit:
```

Figure 5-90. Generate Individual Notification Letters/Labels Screen

1. Select Print (D)isenrollment Notification action.

   The *Select MCP Office* prompt displays. If you are entered into the database as an HCF, your associated MCP office will display as the default.

Select the MCP office

1. Press <Return> to select the default MCP office.
2. Select Device.
3. Enter the Right Margin.

   The individual letter will display/print.

Print an address label for the letter

1. Press <Return> to print the label.

2. Select Device.
3. Enter the Right Margin.

   The individual address label will display/print.

4. Exit the Generate Individual Notification Letters/Labels screen.
5. Exit the Multiple Batch Renewal and Disenrollment Functions Menu.

   The Enrollment Processing Menu displays.

5.11 Outputs and Enrollment Maintenance Reports Menu (OENR)

Menu Path: PAS System Menu → M → EMCP → OENR

The Enrollment Reports Menu contains the Family Batch Enrollment Labels Menu, the Enrollment Rosters Menu, and the Enrollment Summaries Menu. Refer to Figure 5-91. Outputs and Enrollment Maintenance Reports Menu (OENR), page 5-178, and Sections 5.11.1-5.

```
   DRPM   DEERS/Enrollment Maintenance Reports Menu
   ERPM   Enrollment Reports Menu
   PRPM   PCM Reports Menu
   MEFM   MCP Enrollment Form
   APAL   Address Label for Patient

Select Outputs & Enrollment Maintenance Reports Menu Option:
```

Figure 5-91. Outputs and Enrollment Maintenance Reports Menu (OENR)

For these reports, you may print the enrollment roster/report for one or more divisions. If you choose (M)ultiple divisions, the system provides a picklist of divisions from which to choose. Once all or multiple divisions are selected, the Division field is filled with the number of divisions selected. When you are asked to select a division and you want to view a list of divisions, enter ??. Once you enter the division, the Division field is filled in with the division name.

If you enter <^> at the *Report Month & Year OR '^' to enter specific date range* prompt, the system asks for a Report Start Date and a Report Stop Date. Once entered, these dates are displayed in the Dates field.

Before printing, the system will warn you that the report may be complex and that you should queue it to print during non-peak hours. Press <Q> at the *Select DEVICE* prompt to send the report to the print queue to be printed later. A device must be selected for printing these reports, as they cannot be printed to the screen or a slaved device.

5.11.1 DEERS/Enrollment Maintenance Reports Menu (DRPM)

Menu Path: PAS System Menu → M → EMCP → OENR → DRPM

The DEERS/Enrollment Maintenance Reports Menu is used to generate information about conditional enrollment, enrollment/disenrollment discrepancies, DEERS ineligible patients from MCP, and DEERS ineligible patients from PAS. Refer to Figure 5-92. DEERS/Enrollment Maintenance Reports Menu (DRPM), page 5-179, and Sections 5.11.1.1-4.

```
   1      MCP Conditional Enrollment Roster
   2      Enrollment/Disenrollment Discrepancy Report
   3      MCP DEERS Ineligibility Report
   4      PAS DEERS Ineligibility Report
   5      CHCS/DEERS Enrollment Synchronization Report

Select DEERS/Enrollment Maintenance Reports Menu Option:
```

Figure 5-92. DEERS/Enrollment Maintenance Reports Menu (DRPM)

A new report (upon installation of the EBC special release) can be run on demand. This new report provides a count of all enrollees currently assigned the MCP status of Enrolled or Invalid Disenrollment. This report (the CHCS/DEERS Enrollment Synchronization Report is also automatically generated on the first day of each month.

5.11.1.1 MCP Conditional Enrollment Roster

Menu Path: PAS System Menu → M → EMCP → OENR → DRPM → 1

- **Contents**

This report lists, by division, all the newborns and spouses who are currently ineligible in DEERS at the time of enrollment. These beneficiaries are conditionally enrolled in CHCS with an assigned PCM until eligibility can be confirmed. DEERS is notified by CHCS of the conditional enrollment. DEERS will automatically enroll the newborn or spouse when their eligibility is established in DEERS, provided it is established within 120 days of receipt of

the Conditional Enrollment notification from CHCS. If eligibility is not established within 120 days, the conditional enrollment will be deleted in DEERS and in CHCS. A new enrollment must be reentered in CHCS if the newborn is to be enrolled after 120 days.

- **Use/Frequency**

This report should be checked at least weekly. An eligibility check should be requested weekly for each beneficiary on this report. CHCS will automatically correct the "Conditional" status to "Enrolled" whenever a DEERS eligibility transaction indicates that the beneficiary is enrolled in DEERS.

The site should use this report to list those beneficiaries whose conditional enrollments have not become actual enrollments. The user can determine which conditional enrollees need eligibility checks before their enrollments expire and are deleted in CHCS (after 120 days).

- **Special Instructions**

Discrepancies in DEERS and CHCS enrollments and enrollment counts will result if Conditional Enrollments are not resolved routinely. If DEERS enrolls the beneficiary, but CHCS is not aware of this and deletes the conditional enrollment for the beneficiary after 120 days, discrepancies will occur and will be difficult to identify. DEERS enrollment totals will be greater than CHCS enrollment totals for the site.

Conditional enrollments for spouses are currently not supported by TRICARE policy and spouses should not be enrolled until they are eligible.

- **Report Sample**

Refer to Figure 5-93. MCP Conditional Enrollment Roster, page 5-181.

```
NH PORTSMOUTH, VA                                                    22 Jan 1993@1110    Page 1
                              Personal Data - Privacy Act of 1974 (PL 93-579)
                                     MCP CONDITIONAL ENROLLMENT ROSTER
Division: TRIPLER ARMY MEDICAL CENTER
=============================================================================================================
Name                 FMP/SSN         DDS  DOB        Patient Category  Spons  Home Phone   Enrollment Date
   Patient Address                       OHI        PCM               Rank   Work Phone   Auto Disenroll
Date
=============================================================================================================
FARMER,JOANN         30/098-00-0001       11 Nov 70  USN FAM MBR RET    CDR   447-7560     26 May 93
   9987 SUNSET ST                                    LIMBAUGH,ROBERT                       23 Sep 93
   PORTSMOUTH, VA 23701

GLASS,WHITNEY        02/224-13-4285       01 Jul 93  USAF FAM MBR AD   SSG   851-5119     06 Jul 93
   1219 HALE DRIVE                                   WASHINGTON,WAYNE                      03 Nov 93

KELEMAN,CATHERINE    40/359-46-8955       12 JUN 19  USAF FAM MBR AD   CPT   772-3310     14 Jun 93
   303 S CHERRY                                        PARKS,BERNICE                       12 Oct 93

                                                                                Division Total:    3
```

Figure 5-93. MCP Conditional Enrollment Roster

5.11.1.2 Enrollment/Disenrollment Discrepancy Report

Menu Path: PAS System Menu → M → EMCP → OENR → DRPM → 2

Alternate Menu Path: PAS System Menu → M → OMCP → DEMR → 2

- **Contents**

This report is an alphabetical listing of those enrollees whose enrollments/empanelments have an enrollment status of Invalid Enrollment or Invalid Disenrollment (i.e., have been rejected by DEERS) and the discrepancies associated with the invalid enrollments/disenrollments. The discrepancies must be corrected in CHCS so that the enrollment(s) will be accepted by DEERS when retransmitted. Enrollees with a Pending Enrollment status are not included in this report because the enrollment response has not been received from DEERS.

You can generate the Enrollment/Disenrollment Discrepancy Report by entering a date range for enrollment start dates, a date range for enrollment transaction dates, or by selecting all existing discrepancies. The primary sort for the report is by enrolling division name. You can also sort by ACV, MCP status, Discrepancy Code, alpha order, unit, and beneficiary

category. The date an enrollment was entered and the last date the record was modified is included in the report. Discrepancy totals are also included for both MCP status and ACV for all the enrollments within a division.

- **Use/Frequency**

Consult this report to identify enrollments and disenrollments that were rejected because the enrollment or demographic data is incorrect or inconsistent. Invalid enrollments should be corrected and retransmitted so they can be accepted by DEERS.

Run nightly or more often if needed.

- **Special Instructions**

These discrepancies must be manually corrected through the enrollment or disenrollment process. If you do not correct these invalid enrollments/disenrollments, they will remain in CHCS as invalid but are counted as an enrollment or disenrollment. They will not be recorded or counted in DEERS. CHCS enrollment counts will not agree with DEERS until these corrections are made.

The enrollment and disenrollment discrepancy reasons are stored until the enrollment or disenrollment is corrected. Users may enter a date range to view only errors occurring during that period.

Some causes for the discrepancies are:

– Beneficiary is ineligible (for batched enrollments)

– Already enrolled in another area or program (need to invoke reciprocal disenrollment)

– Enrollment start date overlaps a current or former enrollment history segment in DEERS or CHCS

– Enrollee ACV not consistent with DEERS patient eligibility

– Patient category not consistent with FMP or sponsor rank in CHCS

– Sponsor SSN not in DEERS (for batched enrollments)

– Sponsor in DEERS but family member not in DEERS (for batched enrollments)

– CHCS date of birth does not match DEERS date of birth

- DEERS Dependent Suffix (DDS) mismatch between CHCS and DEERS
- Enrollment update or disenrollment rejected by DEERS (usually patient identification has changed in CHCS since enrollment)
- Disenrollment or enrollment cancellation not issued by the enrolling division (i.e., DMIS ID does not match because user is in the wrong division when changing the enrollment data).

- **Report Sample**

Refer to Figure 5-94. Enrollment/Disenrollment Discrepancy Report, page 5-184.

```
                                                                                                    07 Jul 1993@1517
Page 1
                                    Personal Data - Privacy Act of 1974 (PL 93-579)
                                      ENROLLMENT/DISENROLLMENT DISCREPANCY REPORT
                                         From: 06 Jul 1993     To: 07 Jul 1993
================================================================================================================
===
Patient               FMP/SSN         SEX  DOB         Home Phone       Work Phone      Date of Trans   MCP Status
   Sponsor                    Sponsor Unit      Pending Appts  Duty Phone   Discrepancy
================================================================================================================
===
AURELIUS,GERTRUDE    30/808-60-0101   F  04 Jul 1960  H:              W:               06 Jul 1993  INVALID
ENROLLMENT
                              CAMP SWAMPY        NON-MTF       D:444-5555   SSN Not Found in DEERS Database - Verify
S

DELANO,ANNA          02/368-64-6645   F  16 Dec 1983  H:555 555-5444  W:555 555-0912   06 Jul 1993  INVALID
ENROLLMENT
   DELANO,KENNETH             A COMPANY                        D:555-8787   Invalid Enrollment Date Change - Patient
No

DELANO,WILBUR        04/368-64-6645   M  19 Dec 1989  H:390-929-0760   W:               06 Jul 1993  INVALID
ENROLLMENT
   DELANO,KENNETH             A COMPANY                        D:555-8787   Invalid Enrollment - Not Eligible For
Plan

GUILLERO,DANIEL      01/534-48-2466   M  31 Jul 1975  H:              W:               07 Jul 1993  INVALID
ENROLLMENT
   GUILLERO,DONALD            AIR COMBAT COMMAND               D:           Invalid Enrollment - Patient Already
Enroll




----------------------------------------------------------------------------------------------------------------
---
Beneficiaries with a DEERS Discrepancy Code 56: 'Invalid Enrollment - Patient Already Enrolled' will need to be
disenrolled from their current facility and re-enrolled here.
```

Figure 5-94. Enrollment/Disenrollment Discrepancy Report

5.11.1.3 MCP DEERS Ineligibility Report

Menu Path: PAS System Menu → M → EMCP → OENR → DRPM → 3

- **Contents**

The MCP DEERS Ineligibility Report lists all patients who received an ineligible response from DEERS within the past one to five days. It contains the following data: Patient Name, FMP/SSN, Sex/DOB, Date of Transaction, Home Phone, Work Phone, Pending Appointments, Sponsor Name, Sponsor's Unit, Duty Phone, Override Code, MCP Status, and the Process Type (i.e., batch or interactive).

- **Use/Frequency**

This report should be generated daily. This report has been used to identify active-duty who are about to be disenrolled because their enrollments will expire.

- **Report Sample**

Refer to Figure 5-95. MCP DEERS Ineligibility Report, page 5-186.

```
NH PORTSMOUTH, VA                                    11 May 1993@0945         Page
1
                 Personal Data - Privacy Act of 1974 (PL 93-579)
                         MCP DEERS INELIGIBILITY REPORT
                      From: 10 May 1993     To: 11 May 1993
================================================================================
==
Patient              FMP/SSN         SEX  DOB           Date of Trans     Home
Phone     Work Phone     Pending Appts
   Sponsor               Sponsor Unit                        Duty Phone
Override  MCP STATUS         Process Type
================================================================================
==
GALLOWAY,RAE         20/218480614     F   02 Nov 1946   06 May 1993@0900  H:
W:            Appts:
   GALLOWAY,RAE              1st Air Cav                     D:
BATCH

OLSON,SVEN           20/317400514     M   07 Nov 1944   07 May 1993@1503  H:
W:            Appts:
   OLSON,SVEN                1st Air Cav                     D:
INTERACTIVE

WILSON,FAYE          20/408220678     F   01 Jan 1932   06 May 1993@1305  H:
W:            Appts:
   GALLOWAY,R                1st Air Cav                     D:
CONDITIONAL ENROLLMENT  BATCH
```

Figure 5-95. MCP DEERS Ineligibility Report

5.11.1.4 PAS DEERS Ineligibility Report

Menu Path: PAS System Menu → M → EMCP → OENR → DRPM → 4

- **Contents**

The PAS DEERS Ineligibility Report alphabetically lists the names of patients with scheduled appointments who have not had a DEERS check performed within a valid time period or whose DEERS check indicated the patient is ineligible for direct care. It contains the following data: Clinic, Patient Name, FMP/SSN, DOB, Date of Last DEERS Check, Next Appt, Home Phone, Work Phone, and DEERS Status.

Beneficiaries who are identified as USTF enrollees, or whose DEERS check indicates the patient is ineligible for direct care are listed in the second section of the PAS DEERS Ineligibility Report.

- **Use/Frequency**

This report should be generated daily.

- **Report Sample**

Refer to Figure 5-96. PAS DEERS Ineligibility Report, page 5-188.

```
TRIPLER ARMY MEDICAL CENTER                                                    18 Aug 1995@1254    Page 1
                                  PAS DEERS INELIGIBILITY REPORT by DIVISION
                                Personal Data - Privacy Act of 1974 (PL 93-579)
                                         Appointments for 02 Aug 1995
                                                Part 1 of 2
Division: A DIVISION
================================================================================================================
==
Clinic/
   Patient Name     FMP/SSN        DOB           Last DEERS Check    Next Appt.        Home Phone/         Work
Phone
   DEERS Status                                                                                    Clerk
================================================================================================================
==
ALLERGY (T)
-----------
   ABEL,DOUGLAS    99/800-44-0407  07 Apr 1944   18 Aug 1995@0939   06 Aug 1995@1100
   NOT ELIGIBLE                                                                                    THOMAS,DAVID

   SIMPSON,BONNIE  01/362-77-6576  07 Sep 1973   30 Sep 1995@1531   10 Oct 1995@0900    446-6644
   NOT ELIGIBLE                                                                                    DENVER,MICHAEL

CARDIOLOGY (A)
---------------
   SMITH, DANIEL   20/457-65-2398  25 Aug 1960   30 Sep 1955@0802   02 Oct 1995@1000    678-0987
   No Response on Latest DEERS check.  Previous check: ELIGIBLE                                    THOMAS,DAVID

   TUCKER,JANICE   20/161-61-6161  16 Aug 1968   29 Sep 1995@0802   01 Oct 1995@1300    555-2121            977-
3450
   No Response on latest DEERS check. Previous check: NOT ELIGIBLE                                 MILLER,DAVID

================================================================================================================
NOTE: Patients, whose names appear on this report, should be reminded to bring proof of their eligibility at the
time
      of their appointment.
```

Figure 5-96. PAS DEERS Ineligibility Report

```
TRIPLER ARMY MEDICAL CENTER                                                    18 Aug 1995@1254    Page 2
                                  PAS DEERS INELIGIBILITY REPORT by DIVISION
                                Personal Data - Privacy Act of 1974 (PL 93-579)
                                         Appointments for 02 Aug 1995
                                                 Part 2 of 2
Division: A DIVISION
================================================================================================================
Clinic/
   Patient Name     FMP/SSN           DOB           Last DEERS Check    Next Appt.        Home Phone/       Work Phone
   Alternate Care Value               DEERS Direct Care Eligibility                      Clerk
================================================================================================================
ALLERGY (T)
-----------
   ABEL,DOUGLAS    99/800-44-0407     07 Apr 1944   18 Aug 1995@0939   06 Aug 1995@1100
   U/ENROLLED IN USTF MANAGED CARE    NOT ELIGIBLE                                        THOMAS,DAVID

   SIMPSON,BONNIE  01/362-77-6576     07 Sep 1973   30 Sep 1995@1531   10 Oct 1995@0900   446-6644
   U/ENROLLED IN USTF MANAGED CARE    NOT ELIGIBLE                                        DENVER,MICHAEL


(NOTE: The system shall generate Part 2 only if there are DEERS ineligible patients who are enrolled in a USTF Managed
Care Plan to be included in this report.



================================================================================================================
NOTE: Patients, whose names appear on this report section are currently enrolled in a Uniformed Services Treatment
      Facilities (USTF) Managed Care Plan. This facility will not be reimbursed for non-emergency care provided to
      these patients unless their USTF agrees to pay this facility prior to rendering services to the patient.
```

Figure 5-96. PAS DEERS Ineligibility Report (continued)

5.11.1.5 CHCS/DEERS Enrollment Synchronization Report

Menu Path: Secondary Menu → SPL → P

Alternate Menu Paths:

PAS System Menu → M → SPL → P
* PAS System Menu → M → EMCP → OENR → DRPM → 5
* PAS System Menu → M → OMCP → DEMR → 5

- **Contents**

Upon installation of the EBC special release, the system will automatically generate the CHCS/DEERS Enrollment Synchronization Report **on the first of each month** (to insure that enrollment counts are generated on the same date as the DEERS ASCII file generation).

This report presents a count of all enrollees currently assigned the MCP status of Enrolled (with future enrollment end date) or Invalid Disenrollment (i.e., only those categories of patients enrolled in CHCS that have resulted in transmitting an enrollment transaction to DEERS). For sites in DEERS Enrollment mode, current enrollees with the following Alternate Care Values are assumed to have been transmitted to DEERS and are counted in this report:

MCP Patient Type	Alternate Care Value
Active Duty	A TRICARE PRIME (Active Duty)
CHAMPUS Eligible	E TRICARE PRIME (CHAMPUS)
Medicare	D MEDICARE DEMONSTRATION

For sites in Local Empanelment mode, the following current enrollees are counted in this report:

MCP Patient Type	Alternate Care Value
Active Duty	A TRICARE PRIME (Active Duty)
Medicare	D MEDICARE DEMONSTRATION

The data is sorted by the enrolling DMIS ID and by ACV code within each DMIS ID.

Once the report has been generated, a mail bulletin is transmitted to the CPZ MGR mail group indicating that the spool report is ready. Refer to Figure 5-97. DEERS Enrollment Synchronization Report Mail Bulletin, page 5-191.

```
Subj: DEERS ENROLL SYNCH RPT AVAILABLE  Tue, 2 Jul 1997   23:00:46 10 Lines
From: SMITH,DONNA  in  'IN' basket.
------------------------Expires: 26 Jul 1997----------------------------

The DEERS Enrollment Synchronization Report for 1 Jul 1997 is available.

The SPOOL file report name is:  CP CRS SYN-01JUL97-0302-503


Select MESSAGE Action:  IGNORE (in IN basket)//
```

Figure 5-97. DEERS Enrollment Synchronization Report Mail Bulletin

To print the automatically generated report, refer to Section 7.2.2 for instructions on printing spooled reports.

You can also use either of the two menu paths marked with an asterisk (*) above to generate and print the report on demand. When you generate the report through these two menu paths, the data is based on MCP statuses on that date. Queue the report to free your terminal for other enrollment processing functions while the report is generated.

- **Frequency/Use**

This report is automatically generated on the first day of every month to be used by MCP supervisors to determine the number of enrollments in their system. This report captures enrollment statistics in CHCS in the same manner that enrollment statistics are captured in DEERS.

Refer to Figure 5-98. CHCS/DEERS Enrollment Synchronization Report, page 5-192.

- **Report Sample**

```
TRIPLER AMC HONOLULU HI                          15 AUG 1997@1042     Page 1

                CHCS/DEERS ENROLLMENT SYNCHRONIZATION REPORT
                 ***   CHCS ENROLLEES AS OF 1 AUG 1997   ***
-------------------------------------------------------------------------------
ENROLLING DIVISION            DMIS          REGION           ENROLLEES
-------------------------------------------------------------------------------

PEARL HARBOR                  0211            12
    A - TRICARE PRIME (ACTIVE DUTY)                              1,030
    D - MEDICARE                                                     3
    E - TRICARE PRIME (CHAMPUS)                                    910

        TOTAL                                                    1,943

SCHOFIELD BARRACKS            1092            12
    A - TRICARE PRIME (ACTIVE DUTY)                              1,000
    D - MEDICARE                                                    11
    E - TRICARE PRIME (CHAMPUS)                                  1,000

        TOTAL                                                    2,011

TRIPLER                       0322            12
    A - TRICARE PRIME (ACTIVE DUTY)                              3,342
    D - MEDICARE                                                    91
    E - TRICARE PRIME (CHAMPUS)                                  1,568

        TOTAL                                                    5,001

TOTAL PATIENT COUNT:                                             8,955
```

Figure 5-98. CHCS/DEERS Enrollment Synchronization Report

5.11.2 Enrollment Reports Menu (ERPM)

Menu Path: PAS System Menu → M → EMCP → OENR → ERPM

Refer to Figure 5-99. Enrollments Reports Menu (ERPM), page 5-193.

```
   LABL   Family Batch Enrollment Labels Menu
   ROST   Enrollment Rosters Menu
   SUMM   Enrollment Summaries Menu

Select Enrollment Reports Menu Option:
```

Figure 5-99. Enrollments Reports Menu (ERPM)

The Enrollment Reports Menu options allow you to generate information about active duty dependents by unit, alphabetic enrollment by service, case management program enrollment, change in eligibility enrollment, Disenrollees for period by reason code, disenrollment by reason, enrollment roster, exception conditions, OHI enrollment, and patient category enrollment. These options also allow you to create and print labels for families.

5.11.2.1 Family Batch Enrollment Labels Menu (LABL)

Menu Path: PAS System Menu → M → EMCP → OENR → ERPM → LABL

Refer to Figure 5-100. Family Batch Enrollment Labels Menu (LABL), page 5-193 and Sections 5.11.2.1.1-3.

```
   1      Family Batch Enrollment Labels Build Utility
   2      Family Batch Enrollment Labels Print Utility
   3      Incomplete Patient Address Report

Select Family Batch Enrollment Labels Menu Option:
```

Figure 5-100. Family Batch Enrollment Labels Menu (LABL)

The Family Batch Enrollment Labels Menu options allow you to build and print family batch enrollment labels for enrolled and nonenrolled patients, and to sort them by unit or location. During the build process, you may define selection criteria. Labels are generated only for patients who meet the criteria and who have complete address information. You may then print these labels either in their entirety or in subsets.

You may also print an Incomplete Patient Address Report showing the patients who failed the minimum address requirements. After updating these patients' addresses, you may print their labels.

5.11.2.1.1 Family Batch Enrollment Labels Build Utility

Menu Path: PAS System Menu → M → EMCP → OENR → ERPM → LABL → 1

- **Application Description**

The Family Batch Enrollment Labels Build Utility allows you to build family batch enrollment labels for enrolled and nonenrolled patients, and sort them by unit or location. During the build process, you may define selection criteria. Labels are generated only for patients who meet the criteria and who have complete address information. Beneficiaries with expired end dates within the site-defined grace period maintain the MCP status of Enrolled and are included as Enrolled in this utility.

- **Data Entry Process**

Build Family Batch Enrollment Labels

Select (E)nrolled or (N)onenrolled patients or (Q)uit

Select (O)ne, (M)ulitple, (A)ll Unit ID Names

Select (E)nrolled or (N)onenrolled patients or (Q)uit

You may generate labels for enrolled or nonenrolled patients.

Refer to Figure 5-101. Family Batch Enrollment Labels, page 5-195.

```
                        FAMILY BATCH ENROLLMENT LABELS

Enroll Status: ENROLLED
--------------------------------------------------------------------------------
-




--------------------------------------------------------------------------------
--
Select to print labels by (U)nit, (L)ocation or (Q)uit:
```

Figure 5-101. Family Batch Enrollment Labels

If you elect to generate labels by unit, you may select One, Multiple, or All units. If you elect to generate labels by location, you must enter a specific location for which to generate the labels. Location may be one or several ZIP codes or a geographic area, such as Tidewater.

Select (O)ne, (M)ultiple, (A)ll Unit ID Names

Select units with patients receiving labels.

1. You may select from the following search criteria to generate the patient labels:

   – Patient category groups - you may select from patient statuses such as Active Duty, Retired, and so on

   – OHI - you may select patients with or without OHI

   – Enrollment expiration date range - you may specify the specific date range

   – PCM - you may select one, multiple, or all PCMs.

2. Print labels by (D)uty Address or (H)ome Address or (Q)uit.

   Based on the search criteria entered, the system searches the Patient file and generates the appropriate patient labels. All patients that meet the specified search criteria are candidates to have a label generated. However, labels are generated only for patients who have complete address information.

3. Do you want to proceed with this report? No//

4. Recommended Start Time: NOW//

5.11.2.1.2 Family Batch Enrollment Labels Print Utility

Menu Path: PAS System Menu → M → EMCP → OENR → LABL → 2

- **Application Description**

The Family Batch Enrollment Labels Print Utility allows you to print family batch enrollment labels either in their entirety or in subsets.

Print Family Batch Enrollment Labels

- **Data Entry Process**

Access the Family Batch Enrollment Labels Print Utility option on the Family Batch Enrollment Labels Menu

Select (O)ne, (A)ll users, or (Q)uit

Select label batch

(P)rint labels, (D)elete batch or, (V)iew label search criteria

Print a (S)ubset, (A)ll Labels, (T)est printer, or (Q)uit

Access the Family Batch Enrollment Labels Print Utility option on the Family Batch Enrollment Labels Menu

You may search for a list of labels generated by one or all users. The system searches for these label batches and displays them on the Family Batch Enrollment Labels-Print Utility screen. Refer to Figure 5-102. Family Batch Enrollment Labels - Print Utility Screen, page 5-197.

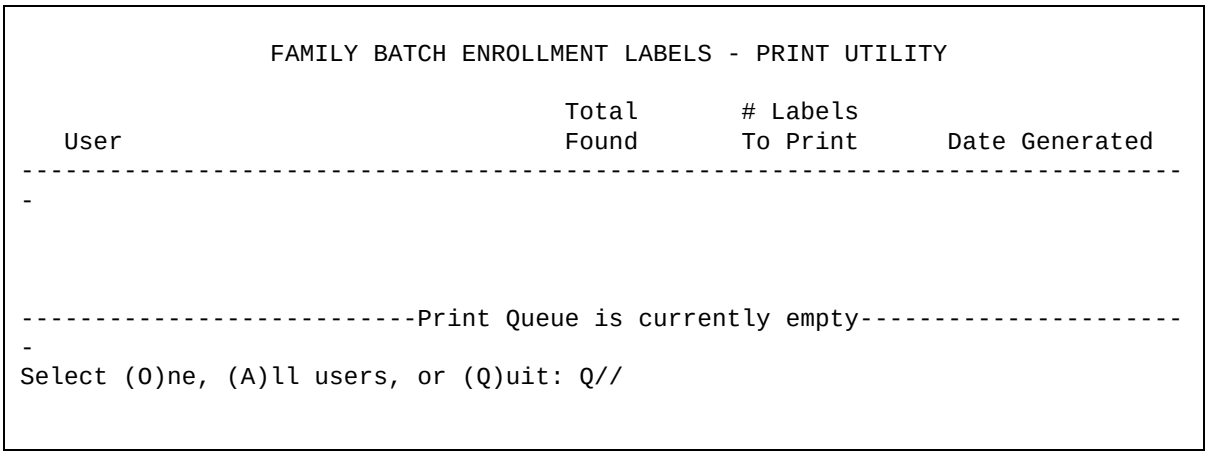


Figure 5-102. Family Batch Enrollment Labels - Print Utility Screen

Select (O)ne, (A)ll users, or (Q)uit

Select label batch

(P)rint, (D)elete batch, or (V)iew label search criteria

The system allows you to:

- Print a label batch - prints all labels, or a subset by specifying how many labels to print
- Delete a label batch
- View search criteria - displays the search criteria used to generate the batch enrollment labels.

Print a (S)ubset, (A)ll Labels, (T)est printer, or (Q)uit.

If Print is selected, the system allows you to print subsets for large print jobs in order to avoid printer jams.

1. Select DEVICE.
2. Quit the Family Batch Enrollment Labels Print Utility screen.

5.11.2.1.3 Incomplete Patient Address Report

Menu Path: PAS System Menu → M → EMPC → OENR → LABL → 3

- **Contents**

The Incomplete Patient Address Report option allows you to print a listing of patients with incomplete address (home or duty) information. This report is generated when you or another user attempt to print MCP patient address labels, and patients with insufficient address information exist. The report lists any patient with an incomplete patient address: sponsor SSN, FMP/DDS, sponsor name, home telephone number, home address (if any), duty telephone number, and duty address (if any).

It is important to remember that more than one user may have been trying to generate patient labels based on different search criteria. As a result, more than one listing of incomplete patient addresses may have been produced.

- **Use/Frequency**

This report should be run each time patient labels are generated.

This report should be run to identify patients who require mailings in MCP but whose addresses need correction prior to label generation.

- **Special Instructions**

As addresses are corrected for beneficiaries on the report, the corrected beneficiaries will be removed from the report. The report will list only the remaining invalid or incomplete addresses. CHCS supports the separate printing of labels for the corrected addresses.

- **Report Sample**

Refer to Figure 5-103. Incomplete Patient Address Report, page 5-199.

```
TIDEWATER MCP                                                              27 Apr 1994@1532      Page 1
                                  Personal Data - Privacy Act of 1974 (PL 93-579)
                                      INCOMPLETE PATIENT HOME ADDRESS REPORT
Address: HOME                                                                Enroll Status: NONENROLLED
Unit ID: ALL
================================================================================================================
==
Name                FMP/SSN                  DDS    Sponsor                          Home Phone
   Patient Home Address                             PATCAT                           Work Phone
                                                    Rank                             Duty Phone
================================================================================================================
==
ANDREWS,JERRY       20/335-89-0112           20     ANDREWS,JERRY                    (804) 223-4788
                                                    USN ACTIVE DUTY
                                                    LT                               (804) 442-2722
BASIL,GEORGE        20/447-09-9844           20     BASIL,GEORGE                     (804) 899-6224
                                                    USA ACTIVE DUTY
   PORTSMOUTH, VA 23711                             SGT                              (804) 899-5176
ELKINS,RONALD       20/448-10-9887           20     ELKINS,RONALD                    (804) 223-4788
   232 DROGHEDA ST                                  USN ACTIVE DUTY                  (804) 337-4778
   PORTSMOUTH, VA                                   CAPT                             (804) 442-2772
NOBEL,ROXANNE       20/387-22-6554           20     NOBEL,ROXANNE                    (804) 224-4133
                                                    USAF ACTIVE DUTY
   PORTSMOUTH, VA 23706                             LT                               (804) 442-2998
STANLEY,ROBERT      20/232-56-2776           20     STANLEY,ROBERT                   (804) 224-9667
                                                    USN ACTIVE DUTY
   PORTSMOUTH, VA 23708                             LT                               (804) 442-3876
WILSON,MICHAEL      20/565-35-2887           20     WILSON,MICHAEL                   (804) 898-8995
                                                    USA ACTIVE DUTY
   PORTSMOUTH, VA 23706                             CPT                              (804) 442-4555

                                                    Total Incomplete Home Addresses:              6
```

Figure 5-103. Incomplete Patient Address Report

5.11.2.2 Enrollment Rosters Menu (ROST)

Menu Path: PAS System Menu → M → OMCP → ERME → ROST

The Enrollment Rosters Menu options allow you to print rosters pertaining to patient enrollment. Refer to Figure 5-104. Enrollment Rosters Menu, page 5-200.

```
   1      AD Family Members by Unit Enrollment Roster
   2      Alphabetic Enrollment Roster by Service
   3      Case Management Program Enrollment Roster
   4      Change in Eligibility Enrollment Roster
   5      Disenrollees for Period by Reason Code
   6      Enrollment Roster Exception Conditions
   7      Reciprocal Disenrollment by Reason Roster
   8      Reciprocal Disenrollment Discrepancy Report
   9      Track User Report
   10     Enrollee Entitlement Discrepancy Report

Select Enrollment Rosters Menu Option:
```

Figure 5-104. Enrollment Rosters Menu

These rosters include current MCP enrolled dependents of active duty enrollees; active duty enrollees by division and branch of service; active duty enrollees with case management records by division, and exception providers with the division; active duty enrollees with pending change of eligibility status; disenrollees by reason code; and enrollees with defined exception conditions. These rosters are normally generated for a specified date range and for selected divisions.

For complete description of these reports, refer to each report below.

5.11.2.2.1 AD Family Members by Unit Enrollment Roster

Menu Path: PAS System Menu → M → OMCP → ERME → ROST → 1

Alternate Menu Path:

PAS System Menu → M → EMCP → OENR → ERPM → ROST → 1

- **Contents**

The AD Family Member by Unit Enrollment Roster option enables you to print a list of all current MCP enrollees with a patient category status of “dependent of active duty.” Current

enrollees include beneficiaries with expired end dates within the site-defined grace period. The report includes sponsor name, SSN, rank, family member name, FMP, DDS, DOB, and enrollment date. The report provides subtotals for the number of enrollees by family and Unit ID, and a grand total of all activated family members. Counts include beneficiaries who have current enrollment statuses of Conditional Enrollment, Pending Enrolled, Enrolled or Invalid Disenrolled. The report is sorted by the sponsor's Unit ID and SSN.

This report lists, by unit of assignment, all family member enrollees whose active duty sponsor is assigned to that unit. The report will help identify TRICARE Prime family member enrollees who may move when their active duty sponsor's unit moves and a family member enrollee population profiled by sponsor unit. The user may select specific units for the report.

- **Use/Frequency**

This report should be run to analyze the enrollee population by sponsor duty stations and/or to determine the affect on family member PCM assignments when a unit is going to change locations. This is a large report and should be run infrequently.

- **Report Sample**

Refer to Figure 5-105. Enrollment Roster for Active Duty Family Members by Unit, page 5-202.

```
WALTER REED AMC                                          21 Jun 2001@1513 Page
3
                  Personal Data - Privacy Act of 1974 (PL 93-579)
             ENROLLMENT ROSTER for ACTIVE DUTY FAMILY MEMBERS by UNIT
Division: DIV A - TRAINING HOSPITAL
Unit:  0121 FIGHTER           SQ
================================================================================
==
Sponsor/                    Sponsor
Enrolled
  Family Members            FMP/SSN/Rank        FMP  DDS   DOB            Date
================================================================================
==
PIGEON,ROBERT E             20/571-69-0000/CPT
--------------------------------------------------------------------------------
--
PIGEON,DANA E                                   30          29 Dec 1961 19 Jun
2001

                                                        Family Member Total:
1
PARISH,STEPHEN J            20/571-69-4700/CPT
--------------------------------------------------------------------------------
--
PARISH,LISA L                                   30          03 Jan 1960 19 Jun
2001

                                                        Family Member Total:
1
                                                                 Unit Total:
2
```

Figure 5-105. Enrollment Roster for Active Duty Family Members by Unit

5.11.2.2.2 Alphabetic Enrollment Roster by Service

Menu Path: PAS System Menu → M → OMCP → ERME → ROST → 2

Alternate Menu Path:

PAS System Menu → M → EMCP → OENR → ERPM → ROST → 2

- **Contents**

The Alphabetic Enrollment Roster by Service option enables you to print, in alphabetical order, a roster of enrollees by branch of service for selected division(s). The roster may be printed for One, Multiple, or All divisions; and within the selected division(s), by One,

Multiple, or All branches of service. The user may select multiple UICs or multiple patient categories and may limit enrollments on the report for those whose enrollment start dates fall within a user defined period. Data provided includes name, FMP/SSN, DDS, DOB, PCM, sponsor, rank, home and work phone numbers, address, enrollment effective date, exception condition text, OHI status, patient category, and MCP status. All enrollments are included regardless of status; e.g., invalid, conditional and pending are also listed. Enrollees with an ACV of "D" and enrolled with expired end dates within the site-defined grace period are also listed.

- **Use/Frequency**

This report should be run to verify the current enrollees and their enrollment status.

This is a large report and should be run infrequently and only to verify the enrollees.

- **Special Instructions**

In CHCS version 4.5, the user may run this report daily to list and verify all the enrollments entered that day or for any date range. The report will print the status of each enrollment.

- **Report Sample**

Refer to Figure 5-106. Alphabetic Enrollment Roster by Service Screen, page 5-204.

```
TRIPLER AMC, HI                                                          22 Jan 1996@1517
Page 1

                            Personal Data - Privacy Act 1974 (PL 93-579}
      ALPHABETIC ENROLLMENT ROSTER By SERVICE
      From 16 Jan 1995 To 19 Jan 1996
      Division TRICARE HCP                                                        MARINE
CORPS
================================================================================================
===
Name                 FMP/SSN            DDS DOB          PCM          Spon Home Phone      Effective
Dates
   Patient Address                          OHI          Patient Category   Rank
Work Phone  MCP Status
================================================================================================
===
PALA,MINDY           31/800-82-0705     05 Jul 70        BANES,JOSEPH  CPL 390-1023  01 Feb 95 - 02 Jun
98
   293854 Highway 67                        USMC FAM MBR AD              Enrolled
   Escondido,CA 92026
PALA,PAUL           20/800-82-0705      12 Aug 72        ABBOT,JAMES   CPL 390-1023  01 Feb 95 - 02 Jun
98
   293B54 Highway 67
   Escondido,CA 92026


MARINB CORP Total:     2

                                                                    Division Total:     2
```

Figure 5-106. Alphabetic Enrollment Roster by Service Screen

5.11.2.2.3 Case Management Program Enrollment Roster

Menu Path: PAS System Menu → M → OMCP → ERME → ROST → 3

Alternate Menu Path:

PAS System Menu → M → EMCP → OENR → ERPM → ROST → 3

- **Contents**

The Case Management Program Enrollment Roster option enables you to print an alphabetical list of all currently enrolled beneficiaries who have been identified as Case Management patients in the local MCP network. The report provides a subtotal for each exception provider in a specified division. Patient data provided includes name, FMP/SSN, DDS, DOB, sponsor rank, home and work phone numbers, address, enrollment effective date, exception condition text, OHI status, patient category, and MCP status.

- **Use/Frequency**

This report should be run as needed to obtain a list of all network case managers recorded in MCP who have enrollees assigned to them.

- **Report Sample**

Refer to Figure 5-107. Case Management Program Enrollment Roster, page 5-206.

```
TIDEWATER

13 Jan 2001@1517                Page 1

Personal Data - Privacy Act 1974 (PL 93-579}
       CASE MANAGEMENT PROGRAM ENROLLMENT ROSTER
       Exception Provider: ADAMSON,GEORGE V
       Division: AIR FORCE MTF DIVISION
================================================================================
==
Name                  FMP/SSN        DDS     DOB     PCM                Spon
Home Phone  Effective Dates
Patient Address      Condition Text     OHI          Patient Category   Rank
Work Phone  MCP Status
================================================================================
==
ROBERTS,HAROLD 20/555-56-6555 09 Feb 50  THOMAS,DAVID   8329749273 23 Aug 00 -
07 Oct 01
  8847 XENIA AVE                                 USAF ACTIVE DUTY
Enrolled
  HAMPTON,VA 23665
                   bleeding ulcer
```

Figure 5-107. Case Management Program Enrollment Roster

5.11.2.2.4 Change in Eligibility Enrollment Roster

Menu Path: PAS System Menu → M → OMCP → ERME → ROST → 4

Alternate Menu Path:

PAS System Menu → M → EMCP → OENR → ERPM → ROST → 4

- **Contents**

This report lists, by division and by end of eligibility category, all enrollees projected to be approaching a change to their eligibility status. The end of eligibility criteria include enrollees approaching their 21st, 23rd, or 65th birthday, as well as enrollees approaching their end of eligibility date. Beneficiaries are listed alphabetically within each end of eligibility category. The report includes the total count of enrollees approaching a potential change in eligibility. Beneficiaries with expired end dates within the site-defined grace period are included in this count.

- **Use/Frequency**

This report should be run weekly to identify those beneficiaries whose original eligibility, at the time of enrollment, will soon change and whose enrollment entitlement may, therefore, change.

- **Special Instructions**

The user should disenroll a beneficiary from TRICARE on their birth date if they meet the end of eligibility criteria for age per the report. The user will use this report as follows:

– In 4.5, CHCS will automatically verify the active duty end of eligibility date on the last day of the month prior to expiration and will correct the date to the new end date in DEERS. However, beneficiaries whose end of eligibility date is corrected in DEERS after the end of the month will not be corrected in CHCS. The user must still check for these beneficiaries.

– In 4.6, CHCS will verify the active duty end of eligibility date on the night the eligibility expires and for 120 additional days, and will correct the date if a change has occurred. The active duty member will be disenrolled only if eligibility has expired according to

the corrected date. The user will also be able to select enrollees by beneficiary category to print.

Note: End eligibility dates in DEERS may not be current resulting in premature disenrollment of active-duty.

- **Report Sample**

Refer to Figure 5-108. Change in Eligibility Enrollment Roster, page 5-208.

```
TIDEWATER

                                                              13 Apr 2001@1517 Page
1

                  Personal Data - Privacy Act 1974 (PL 93-579}
                     CHANGE IN ELIGIBILITY ENROLLMENT ROSTER
                        FROM: 14 Apr 2000  TO: 14 Apr 2001
Division: A Division                          Eligibility Category: APPROACHING
THE AGE OF 21
================================================================================
==
Name                 FMP/SSN        DDS DOB          PCM                Spon
Home Phone  Enrollment Date
Patient Address      Condition Text     OHI          Patient Category   Rank
Work Phone  End Eligibility Date
                                                     Sponsor Name
MCP Status
================================================================================
==
LONG,CHRISTY 02/654-32-1098   05 NOV 80   THOMAS,DAVID   Cpt  234-2344  02 Jun
00
12343 LIBERTY RD                         USA FAM MBR AD                  02 Jun
01
SAN DIEGO, CA 92121
```

Figure 5-108. Change in Eligibility Enrollment Roster

5.11.2.2.5 Disenrollees for Period by Reason Code

Menu Path: PAS System Menu → M → OMCP → ERME → ROST → 5

Alternate Menu Path:

PAS System Menu → M → EMCP → OENR → ERPM → ROST → 5

- **Contents**

The Disenrollees for Period by Reason Code option enables you to print a report which lists by division, the individual enrollees whose disenrollment was entered into CHCS during the user specified date range. Patients are listed under their reason for disenrollment. The user has the option to print some or all of the disenrollment reasons and selected divisions. Reciprocal disenrollments of the local enrollees (by remote sites) are listed under the reason "RM - Remotely Disenrolled." Beneficiaries with expired end dates within the site-defined grace period maintain the MCP status of Enrolled and are NOT included in this report.

- **Use/Frequency**

The report should be run weekly to select those reasons that indicate dissatisfaction with the program or a PCM. This report should be run as needed when disenrollment trends need to be analyzed by the site.

This report should be used to determine patient dissatisfaction with the program or PCM or to analyze trends and frequency in disenrollment. This report can be used to track the beneficiaries who are disenrolling. The report also identifies the category and numbers of the beneficiary who are disenrolling. Specific reasons may be of special interest to the MTF Commander, Lead Agent, or the Quality Assurance review.

- **Special Instructions**

Currently sites may define their own disenrollment reasons in addition to the standard values. In a future release, the site defined disenrollment reasons will no longer be accepted and only standard reasons will be used. Therefore, sites are urged to use the standard values initially as much as possible.

- **Report Sample**

Refer to Figure 5-109. Disenrollees for Period By Reason Report, page 5-210.

```
TIDEWATER                                                    13 Apr 2001@1517 Page
1

                  Personal Data - Privacy Act 1974 (PL 93-579}
                       DISENROLLEES For PERIOD BY REASON
                      FROM: 14 Mar 2001  TO: 14 Apr 2001
       Division: A Division
Disenrollment Reason: EE ENROLLED IN ERROR
================================================================================
==
Name                  FMP/SSN           DDS    DOB          PCM
Spon Home Phone    Disenrollment
Patient Address                                OHI          Patient Category
Rank Work Phone    Date
================================================================================
==
BLITON,KATHRYN         30/278-55-5025   30   09 Apr 69     THOMAS,DAVID
CPT  001535-7116   02 Apr 2001
  4376 Governor Drive                          OHI          USA FAM MBR AD
  Hampton,VA 23665

FARMER,FRANCINE        30/333-66-655    30   02 Sep 70     DEL CARMEN,GLEN R
MAJ  939209-3489   26 Mar 2001
  3322 Wynton Ave                                           USA FAM MBR AD
  Scranton,PA 21776

FARMER,FRANKLIN        20/333-66-6555   20   01 Jan 50     MADISON,MICHAEL
MAJ  619555-5555   12 Apr 2001
  1111 MISSION BLVD                                         USA ACTIVE DUTY
  San Diego, CA 92109

JAVENS,LAURIE          30/478-55-5045   30   09 Feb 53     PRIMARY CARE PNH
SGT  804-367-0093  20  Mar 2001
  11345 Sandy Dr                               OHI          US FAM MBR RET
  San Diego, CA 92124

                                                        Selected Reason Total:
4

                                                       Selected Division Total:
4
```

Figure 5-109. Disenrollees for Period By Reason Report

5.11.2.2.6 Enrollment Roster Exception Conditions

Menu Path: PAS System Menu → M → OMCP → ERME → ROST → 6

Alternate Menu Path:

PAS System Menu → M → EMCP → OENR → ERPM → ROST → 6

- **Contents**

The Enrollment Roster Exception Conditions option enables you to print a report alphabetically listing enrollees, by exception provider with defined exception conditions. The report subtotals each provider specialty and exception provider, and totals all exception providers within the specified division.

- **Use/Frequency**

This report should be used as needed to assess the network case management load by specialty and by individual for enrollees only with MCP providers as case managers.

- **Report Sample**

Refer to Figure 5-110. Enrollment Roster Exception Conditions Report, page 5-212.

```
TIDEWATER
                                                          24 May 2001@1517 Page
1
                  Personal Data - Privacy Act 1974 (PL 93-579}
                     ENROLLMENT ROSTER EXCEPTION CONDITIONS
                       FROM: 24 Apr 2000  TO: 24 May 2001
Exception Provider: ADAMSON,GEORGE V
       Division: A Division
================================================================================
==
Specialty                 FMP/SSN           DDS    DOP          Patient
Category           Effective Dates
   Name                   Condition Text
MCP Status
================================================================================
==
UROLOGIST
---------
  DANNY,PAT             20/111-11-1112         01 Jan 50  USA RET LOS OFFICER
30 Apr 00 - 07 Feb 01
                        Enlarged prostate
Enrolled

  LONG,CRISTY           02/64-32-1098          05 Nov 82  USA FAM MBR AD
10 Apr 00 - 08 Nov 01
                        Urinary infection
Enrolled


Specialty Total:  2


Provider Total:  2
```

Figure 5-110. Enrollment Roster Exception Conditions Report

5.11.2.2.7 Reciprocal Disenrollment by Reason Roster

Menu Path: PAS System Menu → M → OMCP → ERME → ROST → 7

- **Contents**

This report lists those beneficiaries who were reciprocally disenrolled from a remote site by a local CHCS user during the user specified date range. The report identifies each beneficiary, the losing site, and the reason for reciprocal disenrollment; i.e., whether the beneficiary was disenrolled because the beneficiary either was enrolling locally or elected TRICARE Standard rather than TRICARE Prime.

The disenrollments are not grouped by division at this time.

- **Use/Frequency**

This report should be run when reciprocal disenrollment trends and volumes need to be identified or when there is a question about a reciprocal disenrollment issued locally. This is a 132 column report that may be output to a line printer.

> **Note:** The Disenrollees for Period by Reason Report option allows you to print all of the other disenrollment reasons, including Remotely Disenrolled (RM). Remotely Disenrolled are enrollees disenrolled in your system by another site.

- **Report Sample**

Refer to Figure 5-111. Reciprocal Disenrollment by Reason Roster, page 5-214.

```
TIDEWATER

                                                              01 Apr 2001@1517 Page
1

                  Personal Data - Privacy Act 1974 (PL 93-579}
                       RECIPROCAL DISENROLLMENT BY REASON
                       FROM: 01 MAY 2001  TO: 04 May 2001
Exception Provider: ADAMSON,GEORGE V
      Division: A Division
================================================================================
==
RECIPROCAL DISENROLLMENT Reason           DOB           Losing         Facility
Gaining Facility
Patient Name             FMP/SSN                        DMIS ID         Enr
Start Date    Enr Start Date
                         DDS                            Description     Enr End
Date      Enr End Date    User
================================================================================
==
RECIPROCALLY ENROLLED/DISEROLLED
--------------------------------------------------------------------------------
-
  ALLEN,JASON         01/555-33-3555  06 Nov 1970   6501          03 May 2000
02 May 2001  LEE,JUDY                          1
                                            TIDEWATER MCP  01 May 2001   31 May
2001

  ALLEN,VICTORIA      30/555-33-3555  11 Sep 1955   6501          02 May 2000
03 May 2001  LEE,JUDY
                      30                             TIDEWATER MCP 01 May 2001
31 May 2001

  BLACKWELL,GERALD D      20/150-48-9565   02 Oct 1969  6501            02 May
2000     03 May 2001  FONG,MAY
                      20                             TIDEWTER MCP  01 May 2001
31 May 2001

  CLARK,PATRICK J     20/188-40-1205   03 Sep 1957  6501          26 May 2001
02 May 2001  WARD,JOHN
                      20                             TIDEWATER MCP 01 May 2001
31 May 2001

                                    RECIPROCALLY ENROLLED/DISENROLLED Subtotal:
4
                                                 TRICARE MANAGED CARE Total:
4
```

Figure 5-111. Reciprocal Disenrollment by Reason Roster

5.11.2.2.8 Reciprocal Disenrollment Discrepancy Report

Menu Path: PAS System Menu → M → OMCP → ERME → ROST → 8

- **Contents**

When DEERS notifies CHCS that a local CHCS enrollee has been disenrolled in DEERS by a remote site, CHCS must be able to disenroll this beneficiary to release the PCM and reflect the same enrollment status as DEERS. CHCS may be unable to locally disenroll the beneficiary as a result of some beneficiary data discrepancy, such as a patient identification changing since enrollment. If this happens, the beneficiary is listed on this spooled report with the disenrollment data sent from DEERS and the reason the disenrollment could not be completed.

Beneficiaries on this report are not currently grouped by division.

The Reciprocal Disenrollment Discrepancy Report option enables you to print a report containing the discrepancies "Patient Not Enrolled at Losing Facility" and "Patient Not Registered/Not Found at Losing Facility." A mail message is sent daily to the CPZ MGR mail group indicating whether or not discrepancies exist.

- **Use/Frequency**

You should consult this report to identify and correct any reciprocal disenrollments initiated by remote sites that have been received and rejected by CHCS. These discrepancies must be corrected to maintain synchronization of the CHCS and DEERS data.

Often you will need to check the patient's identification in DEERS, identify the patient name in CHCS, change the patient identification to its overall value at enrollment and disenroll the patient.

A mail message is sent daily to the CPZ MGR mail group indicating that discrepancies exist or do not exist. Refer to Figure 5-112. Reciprocal Disenrollment Mail Message, page 5-216. The user MUST print the report and make the necessary corrections.

- **Special Instructions**

This spooled report will be purged after 14 days. If the discrepancies are not corrected, the documentation on the discrepancies is lost. The beneficiary will remain incorrectly enrolled in CHCS even though no longer enrolled at the site according to DEERS. Making the corrections will ensure that the beneficiary PCM slot is freed in the local system and will help ensure that CHCS enrollment counts match those in DEERS.

> **Note:** You should print the Disenrollees for Period by Reason Report to list the beneficiaries who were remotely disenrolled.

```
   Subj: RECIPROCAL DISENROLLMENT HAS COMPLETED
       Thu, 03 Nov 1996 14:50:01 11 Lines
From: POSTMASTER (Sender: GONZALES,MARION} in 'IN' basket.
----------------------------Expires: 02 Feb 1995-----------------
Reciprocal Disenrollment has completed for 03 Nov 1996.

Beneficiaries have been identified as having discrepancies.

The following Reciprocal Disenrollment Discrepancy Report should be generated
so the discrepancies can be corrected: RECIP DISENROLL 03Nov96-1449

Action MUST be taken to update the Reciprocal Disenrollment Discrepancy
information.

This report MUST be Printed Within 14 Days Before Auto-Deletion!!

Select MESSAGE Action: IGNORE (in IN basket)//
```

Figure 5-112. Reciprocal Disenrollment Mail Message

- **Report Sample**

Refer to Figure 5-113. Reciprocal Disenrollment Discrepancy Report, page 5-217.

```
NMC PORTSMOUTH VA

                                                          03 Jun 2001@1517  Page
1

                  Personal Data - Privacy Act 1974 (PL 93-579}
                   RECIPROCAL DISENROLLMENT DISCREPANCY REPORT

       Spool Doc: RECIP DISENROLL 03Jun01-1449
================================================================================
==
Disenrollment Discrepancy Reason                              Gaining Facility
Losing Facility
Patient Name              FMP/SSN    DDS      DOB            DMIS ID
Description         DMIS ID  Description
================================================================================
==
PATIENT NOT ENROLLED AT LOSING FACILITY
---------------------------------------
  BIEGLER,EDWRD J       20/534-48-2444    31 Jul 1985   8888    TEST
6501  TIDEWATER MCP
```

Figure 5-113. Reciprocal Disenrollment Discrepancy Report

5.11.2.2.9 Track User Report

Menu Path: PAS System Menu → M → OMCP → ERME → ROST→ 9

- **Contents**

The Track User Report option enables you to print a report showing MCP enrollment records that have been originated, modified, or had the PCM changed within a specified date range. This report displays the users that originated or modified an enrollment record, or changed the PCM for an enrollment record. This report may be printed for One, Multiple, or All divisions, and within divisions by One, Multiple, or All sponsor SSNs, Patient Category Groups, or Users.

- **Report Samples**

Refer to Figure 5-114. Track User Report by Family, page 5-218, and Figure 5-115. Track User Report by Patient Category Group, page 5-219.

```
TRIPLER ARMY MEDICAL CENTER                                  23 Mar 1995@1306   Page
1
                  Personal Data - Privacy Act 1974 {PL-93-579)
                           TRACK USER REPORT by Family
                        From: 01 Feb 1995 To: 28 Feb 1995
Division: TRIPLER ARMY MEDICAL CENTER
Sponsor SSN: 279-56-5025
================================================================================
==
Patient Name            FMP/SSN               DOB/AGE         PAT            Spon           DMIS
                                                              CAT            Rank           ID
================================================================================================
JONES,WILLIAM H       01/279-56-5025         01 Jan 2001/4y    F41            CPT            6501

   Effective Dates: 01 Nov 1994 - 31 Oct 1995                          Date Enrolled: 31 Oct 1994
        MCP Status: ENROLLED                                             Enrolled by: DEB,SANDRA D
               ACV: E-NCP ENROLLED/DIR.CAR CHA                     Date Last Modified: 27 Feb 1995
       Direct Care: ELIGIBLE                                         Last Modified by: HONORS,JEFFREY
          Medicare: NOT ELIGIBLE                                   Date PCM Last Changed: 06 Apr 1995
      Current PCM:DEL CARMEN,RICHARD                              PCM Last Changed by: BEAN,BAR8ARA B
JONES,FREDERICK T     20/279-56-5025         10 Sep 1964/30Y   Fll            CPT            6501
 Effective Dates: 01 Feb 1995 - 31 Jan 1996                          Date Enrolled: 04 Feb 1995
      MCP Status: ENROLLED                                           Enrolled by: HOLLEY,CONSTANCE
      ACV: A-ACTIVE DUTY/MCP ENROLLED                                Date Last Modified: 17 Jan 1995
      Direct Care: ELIGIBLE                                          Last Modified by: THOMAS,JACXIE J
      Medicare: NOT ELIGIBLE                                         Date PCM Last Changed: 12 Jan 1995
      Current PCM: GONZALBZ,ROBERTO A                             PCM Last Changed by: THOMAS,JACKIE J

JONES,SAHANTNA Y      30/279-56-5025          11 Jun 1963/31Y   P31            CPT            6501

  Effective Dates: 01 Nov 1994 - 31 Oct 1995                          Date Enrolled: 31 Oct 1994
       MCP Status: ENROLLED                                           Enrolled by: DOE,SANDRA D
              ACV: E-MCP ENROLLED/DIR. CARE CHA                      Date Last Modified: 03 Apr 1995
      Direct Care: ELIGIBLE                                          Last Modified by: HONORS,JEFFREY
             Medicare: NOT ELIGIBLE                                  Date PCM Last Changed: 11 Feb 1995
Current PCM: DEL CARMEN,RICHARD R                                 PCM Last Changed by: BBAN,BARBARA B
```

Figure 5-114. Track User Report by Family

```
TRIPLER ARMY MEDICAL CENTER                                  23 Mar 1995@1306 Page
1

                  Personal Data - Privacy Act 1974 {PL-93-579)
                   TRACK USER REPORT by Patient Category Group
                        From: 01 Feb 1995 To: 28 Feb 1995
                      Division: TRIPLER ARMY MEDICAL CENTER
Patient Category Group: ACTIVE DUTY
================================================================================
==
Patient Name            FMP/SSN               DOB/AGE         PAT       Spon        DMIS
                                                              CAT       Rank
================================================================================================

ABEL,CHARLES          20/501-84-0317         26 Nov 1981/23y   F11       CPT         6501


        Effective Dates: 01 Feb 1995 - 31 Jan 1996          Date Enrolled: 01 Feb 1995
             MCP Status: ENROLLED                             Enrolled by: DOE,SANDRA
                    ACV: A-ACTIVE DUTY/MCP ENROLLED     Date Last Modified: 03 Feb 1995
            Direct Care: ELIGIBLE                         Last Modified By: GARRISON,DEBORAH G
               Medicare: NOT ELIGIBLE                     Date PCM Changed: 03 Jan 1995
            Current PCM: MERCER,MICHAEL M              PCM Last Changed by: GARRISON,DEBORAH G

BLITON,CHARLES        20/266-32-4025         04 Sep 1960/35y   F11       1LT         6501

        Effective Dates: 01 Jun 1994 - 31 May 1995          Date Enrolled: 31 May 1995
             MCP Status: INVALID DISENROLLMENT                Enrolled by: HOLLEY,CONSTANCE
                    ACV: A-ACTIVE DUTY/MCP ENROLLED     Date Last Modified: 11 Feb 1995
            Direct Care: ELIGIBLE                         Last Modified By: GARRISON,DEBORAH G
               Medicare: NOT ELIGIBLE                     Date PCM Changed: 19 Jul 1995
            Current PCM: GONZALEZ,ROBERTO A            PCM Last Changed by: HARRIS,KIMBERLEY

BROWN,LESTER L        20/400-87-5879         10 Oct 1965/29y   F11       SSG         6501

        Effective Dates: 01 Mar 1995 - 28 Feb 1996          Date Enrolled: 11 Feb 1995
             MCP Status: INVALID ENROLLMENT                   Enrolled by: HONORS,JEFFREY
                    ACV: A-ACTIVE DUTY/MCP ENROLLED     Date Last Modified: 11 Apr 1995
            Direct Care: ELIGIBLE                         Last Modified By: HONORS,JEFFREY
               Medicare: NOT ELIGIBLE                     Date PCM Changed: 16 Feb 1995
            Current PCM: BARRETT,THERESA A             PCM Last Changed by: GARRISON,DEBORAH G

MARSHALL,DEBBIE A      20/113-45-6726          18 Mar 1960/35y   F11       CPT         6501

        Effective Dates: 01 Mar 1995 - 28 Feb 1996          Date Enrolled: 22 Feb 1995
             MCP Status: ENROLLED                             Enrolled by: LEE,SANDRA
                    ACV: A-ACTIVE DUTY/MCP ENROLLED     Date Last Modified: 03 Apr 1995
            Direct Care: ELIGIBLE                         Last Modified By: HONORS,JEFFREY
               Medicare: NOT ELIGIBLE                     Date PCM Changed: 06 Apr 1995
            Current PCM: DEL CARMEN,RICHARD            PCM Last Changed by: JONES,JACKIE J
```

Figure 5-115. Track User Report by Patient Category Group

5.11.2.2.10 Enrollee Entitlement Discrepancy Report by Family

Menu Path: PAS System Menu → M → OMCP → ERME → ROST→ 10

- **Contents**

The Enrollee Entitlement Discrepancy Report option enables you to print a list of all enrollees with entitlement discrepancies.

You select the enrolling divisions for the report. You receive a message indicating that this is a complex report and asking if you wish to proceed. The report shows the original eligibility, the current eligibility, and the now invalid ACV Use/Frequency.

Entitlement discrepancies can occur when a beneficiary's entitlement changes after enrollment; e.g., active duty to retiree or retiree to Medicare. These enrollees should be disenrolled. Entitlement discrepancies are detected by CHCS whenever a beneficiary receives care and a DEERS eligibility check is performed. A potential active-duty PCS will be reported for evaluation based on their currently assigned UIC in DEERS.

- **Report Sample**

Refer to Figure 5-116. Enrollee Entitlement Discrepancy Report, page 5-221.

```
TRICARE SERVICE AREA (PORTSMOUTH)                                          20 Oct 1995@0804     Page 1
                                  Personal Data - Privacy Act 1974 {PL-93579)
                                   ENROLLMENT ENTITLEMENT DISCREPANCY REPORT
Division: A DIVISION
Entitlement Discrepancy: NO LONGER DIRECT CARE ELIGIBLE
================================================================================================================
Name                      Sponsor SSN    FMP  DDS DOB      Home Ph       Street Address       City      State  Zip
  Pat Cat                 DEERS Sponsor Status
                          Original Entitlement: Direct Care   CHAMPUS       MEDICARE     ACV-Description
                          Current Entitlement:  Direct Care   CHAMPUS       MEDICARE     ACV-Description
================================================================================================================
ABBOTT,ALLEN              800-55-0101   20    01 Jan 1955 (619) 535-1234 10260 Campus Drive   San Diego  CA 92121
  USA ACTIVE DUTY OFFICER
                          Original Entitlement: ELIGIBLE      NOT ELIGIBLE  NOT ELIGIBLE A-ACTIVE DUTY/MCP
ENROLLED
                          Current Entitlement:  NOT ELIGIBLE

CAMPBELL,JANE             800-59-0210   20     02 Feb 1953 (619) 553-4321 55 Pacific Highway  San Diego  CA 92101
  USAF ACTIVE DUTY
                          Original Entitlement: ELIGIBLE      NOT ELIGIBLE  NOT ELIGIBLE A-ACTIVE DUTY/MCP
ENROLLED
                          Current Entitlement:  NOT ELIGIBLE

PROVIDER,DAVID            888-08-0008   20    05 Apr 1967  (619) 287-9876 1 Main Street       San Diego  CA  92117
  USA ACTIVE DUTY ENLISTE
                          Original Entitlement: ELIGIBLE      NOT ELIGIBLE  NOT ELIGIBLE A-ACTIVE DUTY/MCP
ENROLLED
                          Current Entitlement:  NOT ELIGIBLE

ROY,RANDY                 613-22-4444   20    15 May 1952  (619) 321-8765 9467 Hi Park Road   San Diego  CA 92037
  USN ACTIVE DUTY
                          Original Entitlement: ELIGIBLE      NOT ELIGIBLE  NOT ELIGIBLE A-ACTIVE DUTY/MCP
ENROLLED
                          Current Entitlement:  NOT ELIGIBLE
                                                    Total for NO LONGER DIRECT CARE ELIGIBLE: 4
```

Figure 5-116. Enrollee Entitlement Discrepancy Report

```
TRICARE SERVICE AREA (PORTSMOUTH)                                                    20 Oct 1995@0804      Page 2
                                    Personal Data - Privacy Act of 1974 (PL 93-579)
                                       ENROLLMENT ENTITLEMENT DISCREPANCY REPORT
Division: A DIVISION (continued)
Entitlement Discrepancy: SPONSOR RETIRED
================================================================================================================
===
Name                    Sponsor SSN     FMP  DDS  DOB         Home Ph         Street Address       City       State  Zip
   Pat Cat              DEERS Sponsor Status
                        Original Entitlement      Direct Care  CHAMPUS            MEDICARE      ACV-Description
                        Current Entitlement       Direct Care  CHAMPUS            MEDICARE      ACV Description
================================================================================================================
===
ALLEN,THOMAS            359-55-5025      01  1   01 Jan 1945  (619) 522-7293  6745 Clairemont Mesa  San Diego   CA
92120
  A41 USA FAM MBR AD    Retired
                        Original Entitlement:    ELIGIBLE      ELIGIBLE          NOT ELIGIBLE   E-ENROLLED/DIR. CARE CHA
                        Current Entitlement:     ELIGIBLE      CHAMPUS ELIGIBLE  NOT ELIGIBLE   E-ENROLLED/DIR. CARE CHA

CARLTON,CHARLENE        098-78-5432      30  20  31 Mar 1962  (619) 734-5748  456 Mercer Avenue    San Diego   CA
92122
  F11 USAF Active Duty  Retired
                        Original Entitlement     ELIGIBLE      NOT ELIGIBLE      NOT ELIGIBLE   A-ACTIVE DUTY/MCP ENROLL
                        Current Entitlement      ELIGIBLE      CHAMPUS ELIGIBLE  NOT ELIGIBLE   A-ACTIVE DUTY/MCP ENROLL

MILLER,CHARLES L        587-66-3165      20  20  22 Jun 1942  (619) 354-9467  4853 Ruffin Road     San Diego   CA
92123
  F11 USAF Active Duty  Retired
                        Original Entitlement     ELIGIBLE      NOT ELIGIBLE      NOT ELIGIBLE   A-ACTIVEDUTY/MCP ENROLL
                        Current Entitlement      ELIGIBLE      CHAMPUS ELIGIBLE  NOT ELIGIBLE   E-MCP ENROLLED/DIR.CARE
CHA

                                                                                  Total for SPONSOR RETIRED:
3
                                                                                       Total for A DIVISION:
7
                                                                                 Total for Selected Division(s):
7
```

Figure 5-116. Enrollee Entitlement Discrepancy Report (continued)

5.11.2.3 Enrollment Summaries Menu (SUMM)

Menu Path: PAS System Menu → M → OMCP→ ERME → SUMM

The Enrollment Summaries Menu options enable you to generate summary enrollment and disenrollment reports. The disenrollment report shows totals by disenrollment reason within each selected division. The enrollment summary reports show totals by selected categories, such as OHI, patient category status, and PCM. Refer to Figure 5-117. Enrollment Summaries Menu Screen, page 5-223.

```
   1      Disenrollment Summary by Reason
   2      Enrollment Summary Report
   3      OHI Enrollment Summary
   4      Patient Category Enrollment Summary

Select Enrollment Summaries Menu Option:
```

Figure 5-117. Enrollment Summaries Menu Screen

5.11.2.3.1 Disenrollment Summary by Reason

Menu Path: PAS System Menu → M → OMCP → ERME → SUMM → 1

Alternate Menu Path:

PAS System Menu → M → EMCP → OENR → ERPM → SUMM → 1

- **Contents**

The Disenrollment Summary by Reason option enables you to print a report summarizing the number of disenrollees for a specified date range. The report contains a subcount of disenrollees for each reason code, a subtotal for each division, and a grand total for all disenrollees within the specified date range and the specified divisions. Beneficiaries with expired end dates within the grace period maintain the MCP status of Enrolled and are NOT included in this report.

- **Use/Frequency**

This report should be run as needed to select those reasons that indicate dissatisfaction with the TRICARE program or a PCM. In addition, this report should be run when the site needs to determine disenrollment trends on a monthly or quarterly basis for selected reasons.

- **Report Sample**

Refer to Figure 5-118. Disenrollment Summary By Reason Report, page 5-224.

```
TIDEWATER                                                    24 Oct 1996@1146 Page
1
DISENROLLMENT SUMMARY by REASON
From: 24 Sep 1995 To: 24 Oct 1996
Division: A DIVISION
================================================================================
==
Reason Code       Disenrollment Reason
Total
================================================================================
==
  EC              ENROLLMENT CANCELED                                          3
  EE              ENROLLED IN ERROR                                            2
  PN              PROVIDER PREF NOT IN PLAN                                    1
________________________________________________________________________________
__
                                                          Division Total: 6
```

Figure 5-118. Disenrollment Summary By Reason Report

5.11.2.3.2 Enrollment Summary Report (SUMM)

Menu Path: PAS System Menu → M → OMCP → ERME → SUMM → 2

Alternate Menu Path:

PAS System Menu → M → EMCP → OENR → ERPM → SUMM → 2

The Enrollment Summary Report option enables you to print a two-part summary report.

Part I: By Patient Category

- **Contents**

This section shows, by enrolling division and user specified date range, the total enrollments broken out by beneficiary category (active duty, dependent of active duty, retired, dependent of retired, and other). Subtotals are also provided by rank: E1-E4, E5-E9, W1-W4, O1-O10. Consolidated totals are printed for all divisions selected for the report. The counts include all pending, conditional, and invalid enrollments that fall in the report date range.

The column totals contain counts as follows:

#Enrollments - The total number of first-time enrollments entered in CHCS during the reporting period.

#Re-enrolls - The total number of enrollments for beneficiaries who were previously enrolled then disenrolled then reenrolled in this CHCS system.

#Families - The number of new families who enrolled during the report period. A family may be a retiree with no dependents, a dependent only, or a single family with several dependents. Reenrollments are not counted in this total.

#Count Appts - Primary care and specialty care appointments that are made for enrollees to direct care providers. These appointments are counted as workload.

#Non-Count - Primary care and specialty appointments that are made for enrollees to civilian providers. These appointments are not counted as workload.

Total Enrollees - The total number of active duty and non-active duty enrollees in TRICARE Prime as of the last date of the report. Beneficiaries with expired end dates within the site-defined grace period maintain the MCP status of Enrolled are included in this report.

#Disenrolls - The number of disenrollments entered during the reporting period. If a beneficiary is disenrolled twice during the report period, both disenrollments are counted. If the beneficiary was enrolled before the report period then is disenrolled during the report period, that disenrollment is also counted.

#Admissions - The number of admissions for enrollees to a direct care inpatient facility in CHCS during the report period. If an enrollee is admitted twice during the report period with different register numbers, both admissions are counted.

- **Use/Frequency**

This report should be run whenever enrollment totals need to be reconciled to ensure that all enrollments are being recorded in CHCS and to match totals by beneficiary category in DEERS.

- **Special Instructions**

Active duty enrollee counts in CHCS should match the active duty enrollee counts in DEERS after conditional, pending, and invalid enrollments are subtracted. The consolidated counts of non-active duty will not match the total enrollees in DEERS if the contractor is enrolling some of the non-active duty beneficiaries through their system. The totals on this report should be verified, by division, against totals on other reports run for the same date range (i.e., usually with a "To" date of today) as follows:

Compare - Total for Category on the Enrollment Summary Report (Summary by Category).

To - Beneficiary Category Total (active duty, retiree, etc.) on the Patient Category Enrollment Summary (by Patient Category).

Compare - Total for Category (active duty, retiree, etc.) on the Enrollment Summary Report (Summary by Category).

To - Total (by Category) on the Patient Category Enrollment Summary Report (Category by Service).

Compare - #Disenrolls (for the division) on the Enrollment Summary Report.

To: Division Total on the Disenrollment Summary by Reason Report.

Compare - Consolidated totals for active duty (less invalid, pending, and conditional enrollments) on the Enrollment Summary Report.

To - Total enrollments for active duty on the DEERS Enrollment Report.

Compare - Total for Category (for each beneficiary category) on the Enrollment Summary Report (Summary by Category).

To - Number of Enrollees by Patient Type (for each beneficiary category) on the Available PCM Capacity Report (by PCM).

> **Note:** All CHAMPUS eligible beneficiaries must be added together in order to match.

Compare - Total for Category (for active duty, CHAMPUS, and other) on the Enrollment Summary Report (Summary by Category).

To - Total by ACV (ACV = "A" for active duty; ACV = "E" for CHAMPUS eligible; ACV = "D" for Medicare and direct care only) on the DEERS Enrollment Figures.

> **Note:** On the DEERS report, for a DMIS ID, add all totals for ACV = "E" to get total TRICARE Prime enrollees (CHAMPUS eligible beneficiaries). DEERS totals do not include conditional, pending, or invalid enrollments. The DEERS report totals enrollees by their ACV while CHCS totals enrollees by their current patient category.

Part II: By PCM

- **Contents**

The second part of the report contains the same information and selection capabilities as the first part, but totals are reported by PCM. Refer to Section I for a description of the contents of each column on the report. Consolidated totals are also printed for all divisions selected for the report. Pending, conditional, and invalid enrollments are counted.

- **Use/Frequency**

This report should be run whenever enrollment totals need to be reconciled to ensure that all enrollments are being recorded in CHCS and to verify PCM assignment volumes.

- **Special Instructions**

Active duty enrollee counts in CHCS should match the active duty counts in DEERS by DMIS ID after invalid, pending and conditional enrollments are subtracted from the CHCS totals. Consolidated totals for non-active duty should also match by DMIS ID after invalid, pending and conditional enrollments are subtracted from the CHCS totals. The totals on this report should be verified, by division, against totals on other reports run for the same date range (i.e., usually with a "To" date of the first of the coming month to capture all pending enrollments) as follows:

Compare - Total Enrollees by Agreement Type (for each PCM) on the Enrollment Summary Report (Summary by PCM).

To - Number of Enrollees by Agreement Type on the Available PCM Capacity Report (for each PCM)

> **Note:** Pending, conditional, and invalid enrollments are counted in the Enrollment Summary reports and in the Available PCM Capacity report. The totals should match if the reports cover the same time period; i.e., with an end date of the first of the coming month (to capture enrollees from next month).

- **Report Sample**

Refer to Figure 5-119. Enrollment Summary Report, page 5-229.

TIDEWATER MCP 26 Mar 1994@1506 Page 3

ENROLLMENT SUMMARY REPORT

*** Section 1: Enrollment Summary by Category ***

From: Feb 1994 To: Feb 1994

Enrolling Division: Consolidated Grand Total for All Divisions

Category/ Sponsor Rank	#Enrollments / Total Enrollees	#Re-Enrolls / #Disenrolls	#Families / #Admissions	#Count Appts / #Non-count
ACTIVE DUTY				
E1 - E4	2972	324	N/A	1194
	12778	26	24	1058
E5 - E9	1526	0	N/A	2386
	11068	14	112	1527
W1 - W4	21	18	N/A	400
	3604	4	0	157
01 - 010	1060	44	N/A	4117
	4767	34	226	336
Total for Category:	5579	386	N/A	8097
	32217	78	362	3078
FAM MBR OF ACTIVE DUTY				
E1 - E4	4240	34	703	2168
	19590	82	186	399
E5 - E9	401	4	148	4068
	2030	18	166	206
W1 - W-4	12	11	4	412
	850	1	3	86
01 - 010	794	4	230	3199
	5004	96	196	90
Total for Category:	5447	53	1085	9847
	27474	197	551	781
RETIRED	51	1	8	3570
	152	6	152	796
FAM MBR OF RETIRED	12631	108	238	8101
	29378	374	54	16926
OTHER	180	0	30	705
	446	4	24	43

Figure 5-119. Enrollment Summary Report

5.11.2.3.3 OHI Enrollment Summary (SUMM)

Menu Path: PAS System Menu → M → OMCP → ERME → SUMM → 3

Alternate Menu Path:

PAS System Menu → M → EMCP → OENR → ERPM → SUMM → 3

- **Contents**

The OHI Enrollment Summary option enables you to print a report listing the number of current enrollees who have active policies with other health insurance companies. An enrollee covered by multiple policies is reported for each insurance company. The report sorts alphabetically by insurance company name. Insurance Carriers with the most policies are listed before those with fewer policies.

- **Use/Frequency**

This report may be run as needed and may be used by TPC or by the TSC contractor to determine the number of enrollees with Other Health Insurance policies as well as the most widely subscribed Insurance Carriers.

- **Report Sample**

Refer to Figure 5-120. OHI Enrollment Summary Report, page 5-231.

```
TIDEWATER                                                    20 Sep 199600905 Page
1
       OTHER HEALTH INSURANCE ENROLLMENT SUMMARY
================================================================================
=
Short Name          Insurance Company Name                              Total
================================================================================

A M LIFE CO.       A M LIFE CO.                                          1
AAA LIFE INS       AAA LIFE INSURANCE CORP.                              2
AARP GROUP INS     AARP GROUP HEALTH INSURANCE PR                       1
ABAG BENEFITS            ABAG BENEFITS TRUST PC HEALTH                        1
ACADIAN LIFE        ACADIAN LIFE INSURANCE CO                            1

--------------------------------------------------------------------------------
                               Selected OHI Enrollees Total:          6
```

Figure 5-120. OHI Enrollment Summary Report

5.11.2.3.4 Patient Category Enrollment Summary

Menu Path: PAS System Menu → M → OMCP → ERME → SUMM → 4

Alternate Menu Path:

PAS System Menu → M → EMCP → OENR → ERPM → SUMM → 4

- **Contents**

This report shows, by division, the total current enrollees as of the report run date grouped either by patient category, (e.g., A11, A14, N11, A41, A31, F43) or by service affiliation. Sub-totals by beneficiary category are included. The beneficiary categories are active duty, family member of active duty, retired, family member of retired, and other. The counts included pending, conditional, enrolled, and invalid enrolled. Beneficiaries with expired end dates within the grace period maintain MCP status of Enrolled and are included in this report.

- **Use/Frequency**

The site should print this report as needed to determine the distribution of enrollees by service and by beneficiary category/patient category. This report can be used to identify the existence of beneficiaries who were enrolled in error or whose patient categories have changed since enrollment; i.e., who now appear in the Other category or in an invalid patient category such as a civilian category.

- **Special Instructions**

Refer to the Enrollment Summary Report description for guidance on reconciliation of report totals for this report. All reports must cover the same time period in order to be reconciled.

The DEERS Report computes total enrollees by their ACV while CHCS totals enrollees by their current patient category. This difference in the two systems may account for some of the discrepancies in counts by beneficiary category.

In addition, if a patient category changes in CHCS, the Available PCM Capacity report totals will not match the totals on this report. This occurs because the Available PCM Capacity totals represent the patient category of the beneficiary at enrollment, not the current patient category.

- **Report Samples**

Refer to Figure 5-121. Patient Category Enrollment Summary Report (Enrollee Totals by Patient Category), page 5-233, and Figure 5-122. Patient Category Enrollment Summary Report (Patient Category by Service), page 5-234.

```
TIDEWATER                                                20 Sep 199691312 Page
1
                      PATIENT CATEGORY ENROLLMENT SUMMARY
                  **** ENROLLEE TOTALS By PATIENT CATEGORY ****
Division: A DIVISION
================================================================================
=
Patient Category                                                      Enrollee
Total
================================================================================
=
Active Duty
-----------

             All    USA ACTIVE DUTY                                          10
             A14    USMA CADET                                                1
             B11    NOAA ACTIVE DUTY                                          1
             Fll    USAF ACTIVE DUTY                                          1
             N11    USN ACTIVE DUTY                                           3
                                          Active Duty Total:                 16

Fam Mbr Of Active Duty
----------------------
 A41   USA FAM MBR AD                                                       10
             F41    USAF FAM MBR AD                                           2
             N41    USN FAM MBR AD                                            1
                                       Fam Mbr Of Active Duty Total:         13
Retired
-------
             A31    USA RET Los ENLISTED                                      3
                                                        Retired Total:       3

Fam Mbr Of Retired
------------------
              F43     USAF FAM MBR RET                                        1
                                       Fam Mbr Of Retired Total:

Other
-----
            B48     NOAA UNREMARRIED FORM SPOUSE                  2
                                                         Other Total:        2
--------------------------------------------------------------------------------
                                                  Division Total:
35
```

Figure 5-121. Patient Category Enrollment Summary Report (Enrollee Totals by Patient Category)

```
TIDEWATER                                                    20 Sep 199601312 Page
1
                      PATIENT CATEGORY ENROLLMENT SUMMARY
                     **** PATIENT CATEGORY By SERVICE ****
Division: A DIVISION
================================================================================
=
Patient Category Enrollment Summary
================================================================================
=

SERVICE        ACTIVE DUTY  FAM MBR AD   RETIREE    RET FAM MBR   OTHER
TOTAL

 AIR FORCE           1         20           0            0                  3
 ARMY               11         10           3           10                 25
 NAVY                3          3           0            0         0        4
 OTHER               1          1           0            2                  3
 TOTAL              16         31           3           12                 35
```

Figure 5-122. Patient Category Enrollment Summary Report (Patient Category by Service)

5.11.3 PCM Reports Menu

Menu Path: PAS System Menu → M → EMCP → OENR → PRPM → 1

Refer to Figure 5-123. PCM Reports Menu, page 5-234.

```
      1     Available PCM Capacity by Provider Group
      2     Enrollment Roster by PCM
      3     PCM Activity Report
      4     PCM Assignment Change Roster by Reason
      5     PCM Assignment Change Summary
      6     Default PCM/UIC Report
      7     PCM Enrollment Mix Discrepancy Statistical Summary
      8     PCM Enrollment Mix Discrepancy Report

Select PCM Report Menu Option:
```

Figure 5-123. PCM Reports Menu

5.11.3.1 Available PCM Capacity by Provider Group

Menu Path: PAS System Menu → M → EMCP → OENR → PRPM → OMCP → PRPT → 1

- **Contents**

This report lists, for each PCM group and PCM group member, the maximum capacity, patient load, and remaining capacity for each of the PCMs agreements and for each type of patient (active duty, active duty family member, retiree, retiree family member, and other) supported by the agreement. The report counts include conditional, pending, and invalid enrollments. The totals represent the total number of enrollees assigned to the PCM at report run time.

- **Use**

This report should be run to determine the patient load for a PCM and the distribution of enrollees by beneficiary category. This report can be used to predict when a PCM is approaching capacity or has additional room to receive more enrollees. The report also shows the group capacity and the relationship of the members' capacities to the group.

- **Frequency**

This report should be printed for each provider added or updated or to verify current PCM capacities.

- **Special Instructions**

The Enrollment Roster by PCM can be used to verify the totals on this report.

The patient load totals reflect the patient type (active duty, active duty family member, retiree, retiree family member, or other) at the time the patient is enrolled and should be consistent with the DEERS totals by ACV; if the patient's type has changed since enrollment, this report may not agree with the totals on other CHCS reports that total by the patient's current type. The enrollment totals on this report will always differ from the total enrollee counts in DEERS by the total of all the conditional, pending (future), and invalid enrollments in CHCS. DEERS counts only valid current enrollments.

- **Report Sample**

Refer to Figure 5-124. Available PCM Capacity by Provider Group, page 5-237.

```
TIDEWATER                                                                                    29 Sep 1993@1041      Page
1
                                        AVAILABLE PCM CAPACITY by PROVIDER GROUP
================================================================================================================================
==
Provider Group                                                  Maximum      Number of        Number of
   PCM                                Agreement                 Patient      Enrollees By     Enrollees By
Remaining
      Agreement Type                  Start/End Dates           Capacity     Agreement Type   Patient Type   Capacity
================================================================================================================================
==
CARDIOLOGY PNH
   MTF MTF STAFF                      07 May 1993 - 07 May 1996 500                  1                    499 (a)
      MCA MCP/ACTIVE DUTY                                       200
      MCP MCP/CHAMPUS ELIGIBLE                                                                    1
--------------------------------------------------------------------------------------------------------------------------------
--
Group Total:                                                    500                  1                    499
--------------------------------------------------------------------------------------------------------------------------------
--
   CARDIOLOGY PNH
      MTF MTF STAFF                   07 May 1993 - 07 May 1996 500                                        499 (b)
--------------------------------------------------------------------------------------------------------------------------------
--
Provider Total:                                                 500                  0                    499
--------------------------------------------------------------------------------------------------------------------------------
--



(a)  REMAINING CAPACITY can be distributed over ALL Patient Types LINKED/COVERED by that Agreement Type.
(b)  Individual Provider Capacity may be LIMITED by the OVERALL Maximum Patient Capacity of the PROVIDER GROUP and
     Patients ALREADY assigned to Other PCMs within the PROVIDER GROUP.
(c)  Group/Providers do NOT include UNLIMITED (UNL) capacities.
```

Figure 5-124. Available PCM Capacity by Provider Group

5.11.3.2 Enrollment Roster by PCM

Menu Path: PAS System Menu → M → EMCP → OENR → PRPM → OMCP → PRPT → 2

- **Contents**

This report lists, by division, all the PCMs that have current TRICARE Prime enrollees assigned to the division. The enrollees assigned to each PCM are listed under the PCMs name. A PCM will appear in each division where their enrollees are assigned. All enrollees are listed including those with a pending (future), conditional, and invalid status. The user may select specific PCMs or divisions to print. The report provides a enrollee subtotal for each PCM.

- **Use**

This report should be run as follows: (1) when there is a problem with PCM assignments, (2) to verify actual assignments to each PCM at the beneficiary level against the totals printed on the Available PCM Capacity report, (3) to identify the actual enrollees assigned to a PCM. This report should be run specifically to perform the following:

– Verify individual enrollee PCM assignments

– Verify beneficiary PCM assignments following a Batch PCM Reassignment

– Verify that enrollees assigned to a PCM are also assigned to the correct division

– Forward a list of enrollees to each PCM

– Determine the MCP enrollment status of each enrollee assigned to the PCM

– Compare enrollee counts with the Available PCM Capacity Report for a PCM.

- **Frequency**

As needed.

- **Report Sample**

Refer to Figure 5-125. Enrollment Roster by PCM, page 5-239.

```
TRIPLER AMC, HI                                                                                           08 Jul 1993@1403      Page 1
                                                    Personal Data - Privacy Act of 1974 (PL 93-579)
                                                              ENROLLMENT ROSTER BY PCM
                                                        Provider Group: THACKER PROVIDER GROUP
Division: A DIVISION
=================================================================================================================================
PCM
   Name                         FMP/SSN         DDA      DOB                                Spon    Home Phone      Effective Dates
      Patient Address                                    OHI           Patient Category   Rank    Work Phone      MCP Status
================================================================================================================================
PIERCE,MATTHEW
--------------
   BRADY,GREG                   01/234-23-4234           01 Jan 82                          CAPT    405-555-3455   26 May 93 - 26 May 98
     2304 Main St.                                                     USA FAM MBR AD               405-555-4321   Enrolled
     Los Angeles, CA 91000

SCOTT,MATTHEW
--------------
   MORRISON,MICHAEL             20/234-23-4117           14 Jul 65                          CAPT    405-555-6677   17 May 93 - 17 May 98
     18 Elm Avenue                                                     USA ACTIVE DUTY                             Enrolled
     St. Louis, MO 43211
                                                                                                                    Division Total: 2
```

Figure 5-125. Enrollment Roster by PCM

5.11.3.3 PCM Activity Report

Refer to Section 6.4.3.4, for a description and a sample of the PCM Activity Report.

5.11.3.4 PCM Assignment Change Roster by Reason

Menu Path: PAS System Menu → M → EMCP → OENR → PRPM → OMCP → PRPT → 4

- **Contents**

This report lists, by PCM reassignment reason and by losing PCM, each enrollee who has been reassigned to a new PCM within a user specified date range. Invalid, conditional, and pending enrollments are included. Totals are provided for all beneficiaries and for each change reason.

- **Use**

The site may use this report to identify those PCMs who are losing patients due to patient dissatisfaction or for reasons that may be an alert to the Quality Assurance review. Trends in reassignment preference and in reassignment volume may also be assessed with this report as well as the patients involved in the reassignment.

- **Frequency**

This report should be printed whenever PCM performance and reassignment frequency and volumes need to be analyzed at the provider detail level.

- **Report Sample**

Refer to Figure 5-126. PCM Assignment Change Roster by Reason, page 5-241.

TIDEWATER 01 Oct 1993@1606 Page 1

PCM ASSIGNMENT CHANGE ROSTER by REASON
Personal Data - Privacy Act of 1974 (PL 93-579)
From: 23 Jun 1993 to: 01 Oct 1993
REASON: DE DATE ASSIGNED IN ERROR

Provider Changed From / Enrollee Name	FMP/SSN	DDS	Spon Rank	Patient Category / MCP Status	Provider Changed To	Assign Date / Change Date
BLONDELL,AMY						
BLINTON,KATHRYN	30/278-55-5025	30	COL	USA FAM MBR AD	EAKLE,THOMAS K	01 Oct 93
				Enrolled		01 Oct 93
JAVENS,KATHRYN	01/478-55-5045	1	SFC	USA FAM MBR RET	DOBLES,WILLIAM	01 Oct 93
				Enrolled		01 Oct 93
					Losing PCM Total	2
BLONDELL,AMY						
BLINTON,KATHRYN	30/278-55-5025	30	COL	USA FAM MBR AD	EAKLE,THOMAS K	01 Oct 93
				Enrolled		01 Oct 93
JAVENS,KATHRYN	01/478-55-5045	1	SFC	USA FAM MBR RET	DOBLES,WILLIAM	01 Oct 93
				Enrolled		01 Oct 93
					Losing PCM Total	2
CRAWFORD NEUROLOGY						
CRAWFORD JOE	20/554-27-7243	30	ENS	USN ACTIVE DUTY	CRAWFORD NEUROLOGY	14 Jul 93
				Enrolled		14 Jul 93
CRAWFORD JACQUI						
CRAWFORD,JIM	20/551-27-7242		LT	USN ACTIVE DUTY	EMERSON,JACK	01 Jul 93
				Enrolled		01 Jul 93
EDDY,JESSICA	01/112-27-7242		ENS	USA FAM MBR AD	ALEXANDER,STEPHEN	29 Jun 93
				Enrolled		29 Jun 93
JAVENS,KAITLYN	01/478-55-5045	1	SFC	USA FAM MBR RET	DOBLES,WILLIAM	01 Oct 93
				Enrolled		01 Oct 93
					Losing PCM Total	3

Figure 5-126. PCM Assignment Change Roster by Reason

5.11.3.5 PCM Assignment Change Summary

Menu Path: PAS System Menu → M → EMCP → OENR → PRPM → 5

- **Contents**

This report prints, by losing PCM and for a user specified date range, the number of enrollees who have been reassigned to a new PCM and the reason for the change. Invalid, pending, and conditional enrollments are included in the counts. Totals are provided by change reason and by division.

- **Use**

This report may be used to identify, at a summary level, PCM reassignment activity, the reasons for reassignment, and the PCMs who are losing patients frequently and may present a Quality Assurance issue. Positive and negative trends in reassignment preference and in reassignment volume may also be assessed with this report.

- **Frequency**

This report should be printed whenever PCM performance and reassignment trends need to be analyzed at a summary level.

- **Special Instructions**

This report should be analyzed in combination with the Disenrollment Summary by Reason to determine when there is dissatisfaction with the TRICARE program.

- **Report Sample**

Refer to Figure 5-127. PCM Assignment Change Summary, page 5-243.

```
TIDEWATER                                                29 Sep 1993@1349     Page 1
                          ASSIGNMENT CHANGE SUMMARY FOR PCM
                         From: 21 Jun 1993  To: 29 Oct 1993
                            Previous PCM: CARDIOLOGY PNH
================================================================================
   Assignment Change Reason                                              Enrollees
================================================================================
   PM     PATIENT MOVED                                                         1
   DI     PROVIDER DIED                                                         2

                                                      Previous PCM Total:    3
```

Figure 5-127. PCM Assignment Change Summary

5.11.3.6 Default PCM/UIC Report

Menu Path: PAS System Menu → M → EMCP → OENR → PRPM → 6

- **Contents**

This option produces a report that shows the association between UICs and default PCMs. The report lists UIC, Unit Name, PCM, Provider Group, Agreement, and Start and End Dates. Default PCMs are only valid for active duty enrollments to MCP. The report can be sorted by UIC or by Default PCM.

- **Use**

Maps PCMs to UICs.

- **Frequency**

As needed.

- **Report Sample**

Refer to Figure 5-128. Default PCM/UIC Report, page 5-245.

```
MCP DIVISION                                        02 Feb 1995@1506    Page 1
                  Personal Data - Privacy Act 1974 (PL-93-579)
                               Default PCM/UIC Report
                                *** Sorted by UIC ***
================================================================================
UIC        Unit Name
PCM                        Provider Group   Agr   Start Date   Stop Date
================================================================================
11101      1ST MARINES
  ARGENTINIA,ALEXANDER   SAIC INTERNAL    CON   1 Oct 1993   30 Sep 1994

FF414      USS AQUILA
  BAHAMAS,BARBARA        SAIC INTERNAL    CON   1 Aug 1993   30 Jul 1994

LE1CF602   1912 COMMUNICATIONS GP
  ARGENTINA, ALEXANDER   SAIC INTERNAL    CON   1 Oct 1993   30 Sep 1994









================================================================================
** Indicates UIC code has been inactivated.
```

Figure 5-128. Default PCM/UIC Report

5.11.3.7 PCM Enrollment Mix Discrepancy Statistical Summary

Menu Path: PAS System Menu → M → EMCP → OENR → PRPM → 7

- **Contents**

This report lists PCM Beneficiary Categories that have discrepancies. The discrepancies are identified with an asterisk or flag ("Y"). This report identifies patient loads that include beneficiaries whose ages are outside the PCM's age range preferences, or if the PCM Beneficiary Category Capacity is lower than the current assigned patients. The report lists the Provider Group, Agreement Type, Agreement Dates, Maximum Patient Capacity, Age Range to Apply Overall, Total Assigned, and the PCM Beneficiary Category, Age Range, Capacity, and Patients out of Age Range.

- **Use**

Identifies two potential problems in the way patients are being assigned to PCMs: 1) when enrolled beneficiaries are outside the PCM's accepted age range, and 2) when number of enrollees exceeds the PCM's capacity.

- **Frequency**

As needed.

- **Report Sample**

Refer to Figure 5-129. PCM Enrollment Mix Discrepancy Statistical Summary Report, page 5-247.

TRIPLER ARMY MEDICAL CENTER 24 Oct 1995@1440 Page 1

Personal Data - Privacy Act 1974 (PL-93-579)

PCM ENROLLMENT MIX DISCREPANCY STATISTICAL SUMMARY
by Provider group

Provider Group: WOLLIN GROUP PCM CAPACITY

Agreement Type: NON - NON-NETWORK/EXCEPTION
Agreement Dates: 29 Aug 1995 - 28 Aug 1996
Group PCM: Yes

Maximum Patient Capacity: 30 Age Range to Apply Overall: 1 - 2
Total Assigned: 17

PCM Beneficiary Category	Age Range	Capacity	Total Assigned	Pat out of Age Range
ACTIVE DUTY	1 - 2			
ACTIVE DUTY FAMILY MEMBER	1 - 2	30	11	8
RETIREE	1 - 2	0		
RETIREE FAMILY MEMBER	1 - 2	0		
OTHER	1 - 2	0	6*	2

THE FOLLOWING INDIVIDUAL PROVIDERS WITHIN THIS GROUP HAVE EITHER
CAPACITY OR AGE RANGE DISCREPANCIES AS INDICATED:

Figure 5-129. PCM Enrollment Mix Discrepancy Statistical Summary Report

```
       Provider: WOLLIN,MAGDALENA
 Agreement Type: NON - NON-NETWORK/EXCEPTION
Agreement Dates: 29 Aug 1995 - 28 Aug 1996

Maximum Patient Capacity:    18    Age Range to Apply Overall: 16 -
          Total Assigned:    17
=========================================================================
                                                    Total    Pat out of
PCM Beneficiary Category     Age Range Capacity    Assigned   Age Range
=========================================================================
ACTIVE DUTY                   16 -             0         11           8
ACTIVE DUTY FAMILY MEMBER     16 -
RETIREE                       16 -
RETIREE FAMILY MEMBER         16 -
OTHER                         16 -             0          6*          2
=========================================================================




(*) indicates # of beneficiaries Assigned is greater than Capacity.
```

Figure 5-129. PCM Enrollment Mix Discrepancy Statistical Summary Report (continued)

5.11.3.8 PCM Enrollment Mix Discrepancy Report

Menu Path: PAS System Menu → M → EMCP → OENR → PRPM → 8

- **Contents**

This report includes the statistics from the PCM Enrollment Mix Discrepancy Summary Report and the names of the individual beneficiaries who are currently assigned to PCMs in categories where the number of assigned beneficiaries exceed the PCM's capacity for that category, or whose age is outside the PCM's age range preference. The report lists the DMIS ID, sponsor SSN/FMP, beneficiary name, PATCAT, sponsor rank, age, home and duty zip codes, home phone number, date assigned, and reason, and indicates if there is a case manager. The user may choose to sort the report by PCM, by MCP Provider Group, or by Beneficiary.

- **Use**

Identifies two potential problems in the way patients are being assigned to PCMs: 1) when enrolled beneficiaries are outside the PCM's accepted age range, and 2) when number of enrollees exceeds the PCM's capacity.

- **Frequency**

As needed.

- **Report Sample**

Refer to Figure 5-130. PCM Enrollment Mix Discrepancy Report, page 5-250.

PORTSMOUTH NH 15 Jun 1995@1530 Page 1

Personal Data - Privacy Act of 1974 (PL 93-579)
PCM ENROLLMENT MIX DISCREPANCY REPORT by PCM

PCM: BENJAMIN,ARTHUR

Provider Group: DE ANZA PEDIATRIC GROUP — Maximum Patient Capacity: 100
Agreement Type: CON - CONTRACT — Total Assigned: 82
Agreement Dates: 01 Jan 1995 - 31 Dec 1995 — Age Range to Apply Overall: -
Group PCM: YES

PCM Beneficiary Category	Age Range	Capacity	Total Assigned	Pat out of Age Range
ACTIVE DUTY		0		
ACTIVE DUTY FAMILY MEMBER	0 - 18	75	82*	Y
RETIREE		0		
RETIREE FAMILY MEMBER	0 - 16	25		
MEDICARE		0		
OTHER		0		

(*) indicates # if beneficiaries Assigned is greater than Capacity

PCM Beneficiary Category: ACTIVE DUTY FAMILY MEMBER

DMIS ID	Spon SNN	FMP	Beneficiary Name	Pat Cat	Spon Rank	Case Mgmt	Age	Home Zip	Duty Zip	Home Phone	Date Assigned	Reason
1384	213-76-4345/02		JACKSON,ADRIANNE	K84	AO3	N	13	92029	92121	619-567-9876	15 Dec 1994	EX
1384	213-76-4345/03		JACKSON,THOMAS	K84	A03	N	8	92029	92121	619-567-9876	16 Feb 1995	EX
1384	213-76-4345/04		JACKSON,WINDSOR	K84	A03	N	4	92029	92121	619-567-9876	16 Feb 1995	EX
1384	213-76-4345/05		JACKSON,ZELDA	K84	A03	N	03M	92029	92121	619-567-9876	22 May 1995	EX
3002	111-75-9620/02		ABLE,JOHN	K84	NE5	N	17	92134	92122	619-345-2534	8 Apr 1995	EX
3002	138-83-6549/02		SMITH,ALEXIA	K84	AO5	Y	19	92211	92121	619-999-3353	3 Jan 1995	EX/AX
6214	111-57-8533/04		MIDLER,NANCY	K84	FE5	N	5	92117	92121	619-863-5545	30 May 1995	EX
6214	140-57-8533/02		RODRIQUEZ,HECTOR	K84	FE5	N	18	92117	92121	619-863-5545	4 Oct 1994	EX
6214	140-57-8533/03		RODRIQUEZ,TERRANCE	K84	FE5	N	15	92117	92121	619-863-5545	4 Oct 1994	EX
6214	164-75-9620/02		GEARY,CONNIE	K84	AE2	N	3	92323	92121	619-567-4343	17 Mar 1995	EX

Figure 5-130. PCM Enrollment Mix Discrepancy Report

```
... [etc. There would be 82 names altogether, if the list were completed.]




                                                  Active Duty Family Members assigned to this PCM    = 82
                                        Active Duty Family Members assigned to this PCM in excess of capacity (EX)  =  7
                                Active Duty Family Members assigned to this PCM who are out-of-age-range (AX)      = 14
                                                      Total beneficiaries assigned to this PCM    = 82
                                          Total beneficiaries assigned to this PCM in excess of capacity (EX)   =  3
                                       Total beneficiaries assigned to this PCM who are out-of-age range (AX)  = 14
```

Figure 5-130. PCM Enrollment Mix Discrepancy Report (continued)

5.11.4 MCP Enrollment Form (MEFM)

Menu Path: PAS System Menu → M → EMCP → OENR → MEFM

- **Contents**

The MCP Enrollment Form option allows you to print an MCP enrollment form for a specified MCP patient. This form includes the enrollment date and ending eligibility/enrollment date; patient name, and identifying data; sponsor name and identifying data; PCM and place of care data; insurance company and policy data; and case management involvement.

The form additionally displays a site-definable eligibility, benefits, and responsibility statement for the patient; an area for the patient's signature and date of signing; and an area to indicate the record room for the patient.

- **Use/Frequency**

When necessary.

- **Report Sample**

Refer to Figure 6-77. Managed Care Enrollment Form, page 6-134.

5.11.5 Address Label for Patient (APAL)

Menu Path: PAS System Menu → M → EMCP → OENR → APAL

- **Application Description**

The Address Label for Patient option allows you to print an address label for one or more patients.

- **Use/Frequency**

When necessary.

- **Report Sample**

Refer to Figure 6-78. Patient Address Label, page 6-136.

5.12 Batch PCM Assignment/Reassignment of Enrollees

Menu Path: PAS System Menu → M → BMCP

- **Security Keys**

Refer to Section 5.12.1 Batch PCM Reassignment (BPCM), page 5-254 and Section 5.12.23 Active Duty Enrollee UIC Maintenance Report, page 5-269.

- **Required Fields**

Refer to Section 5.12.1 Batch PCM Reassignment (BPCM), page 5-254 and Section 5.12.2 Family PCM Reassignment, page 5-263.

- **Application Description**

The Batch PCM Reassignment options allow you to reassign a group of enrollees to a new PCM without having to do individual reassignments. The Batch PCM Reassignment option allows you to reassign patients using the following methods:

Reassign All - Reassign all the patients assigned to the current PCM to a new gaining PCM.

By Beneficiary Category - Reassign a group of enrollees of the same beneficiary category from the current PCM to a new gaining PCM. You can reassign only one beneficiary category or many beneficiary categories at the same time.

By UIC - Reassign a group of active-duty enrollees with the same Station/Unit from the current PCM to a new gaining PCM. You can reassign only one valid UIC type at a time. You cannot change the UIC with this option.

Family - Reassign a family or selected members of a family to a new PCM

Multiple PCMs - Reassign patients assigned to the current PCM to more than one PCM within the same provider group. Reassignments proceed until the first PCMs capacity is full, then to the second PCM until capacity is full, then to the third PCM, etc.

In addition, a variety of reports are generated as a result of the Batch PCM Reassignment Process

Enrollee/Patient Assignment Notification - Generated for each patient who is reassigned using the Batch PCM Reassignment option. The notice, which can be folded and placed in a window envelope, informs the patient of the reassignment and includes directions and other information about the new PCM's place of care.

Provider Notification Roster - Lists all patients that have been reassigned to a PCM using the Batch PCM Reassignment option since a specified date. A cover letter can also be generated to include the PCM's payment address and the MCP office that generated the roster. This may be mailed to the gaining and losing PCMs as notification of the change.

PCM Reassignment Report - A three-part report that lists the results of a Batch PCM Assignment action:

Part I lists the patients who have been reassigned.

Part II lists any patients who were not successfully reassigned.

Part III lists any appointment with the prior PCM that are scheduled for the patients listed in Part I.

5.12.1 Batch PCM Reassignment (BPCM)

Menu Path: PAS System Menu → M → BMCP → BPCM

- **Security Keys**

  CPZ PCM BATCH

- **Required Fields**

  Current PCM
  PCM Agreement
  Specialty
  Location
  Agreement Type *
  Gaining PCM
  Assignment Reason

* Required if selected as search criteria.

- **Application Description**

The Batch PCM Reassignment option allows you to reassign the patients of one PCM to one or more other PCMs. You may enter the name of the current PCM and select the appropriate agreement for that PCM. You may select subsets of patients to reassign by Patient Type, or by UIC for active duty only. The system then prompts you either to assign a gaining PCM who meets certain search criteria, to choose one or more gaining PCMs from a list of all PCMs in the current PCM's provider group, or to transfer patients from one place of care to another for the same provider. During the PCM reassignment process, you may view the gaining PCM's Assignment Preferences and/or Place of Care information.

You may also reassign active duty enrollees from one PCM to another based on the enrollee's UIC. Upon entry of a given UIC code, the names of all PCMs who have active duty enrollees with that UIC code display. You may override the default and specify another gaining PCM. A PCM assignment change reason shall be recorded.

Following a reassignment, the system generates a mail message informing appropriate personnel of the completion of reassignment, then creates and stores a PCM Reassignment Report to be printed at a later time.

Batch PCM Reassignment changes the enrolling division if the new PCM practices in another location. The user must make this change for each enrollee in the Enrollment module. The user will select each PCM and reassign their enrollees to a new PCM.

Reassign all a PCM's patients to another PCM

- **Data Entry Process**

Access the Batch PCM Reassignment option on the Batch PCM Reassignment Menu

Select the PCM agreement

Select the beneficiary category

Select the search criteria for change (specialty, location, and agreement type)

Select the gaining PCM

Access the Batch PCM Reassignment option on the Batch PCM Reassignment Menu

The Batch PCM Reassignment screen displays. Refer to Figure 5-131. Batch PCM Reassignment Screen - Without Data, page 5-256.

```
                          BATCH PCM REASSIGNMENT
      Current PCM:                          Gaining PCM:
   Provider Group:                       Provider Group:
    PCM Agreement:                Gaining PCM Agreement:
 Total Enrollees:              Total Available Capacity:
      Active Duty:                           Location:
 AD Family Member:                         Specialty:
          Retiree:                Beneficiary Categories:
RET Family Member:                               UIC:
         MEDICARE;
            Other:
--------------------------------------------------------------------------------
-




--------------------------------------------------------------------------------
--
Select (C)urrent PCM, (U)IC, or (Q)uit: C//
```

Figure 5-131. Batch PCM Reassignment Screen - Without Data

1. Select (C)urrent PCM at the action bar.

2. Enter the Current PCM Name.

   If the current PCM belongs to more than one provider group, a list of the provider groups displays, with the *Select PCM PROVIDER GROUP* prompt. Enter the number identifying the correct provider group and press <Return>.

Select the PCM agreement

The middle Select Window displays all provider agreements with PCM exceptions. You select which agreement to process. Only one agreement can be processed at a time.

The PCM agreement you select displays in the top Display Window on the left side. Also displayed is the number of patients (by beneficiary category) currently assigned.

The beneficiary categories are those that define MCP-enrolled status:

Active Duty
Retired
Retiree Family member
Other
Medicare
Active Duty Family Member

Select the beneficiary category

The middle Select Window displays all beneficiary categories that apply to the enrollees currently assigned to the current PCM. Refer to Figure 5-132. Batch PCM Reassignment Screen - With Data, page 5-258. For example, if patients with the beneficiary categories ADY and AD Family Member are assigned to the current PCM, then only those types display.

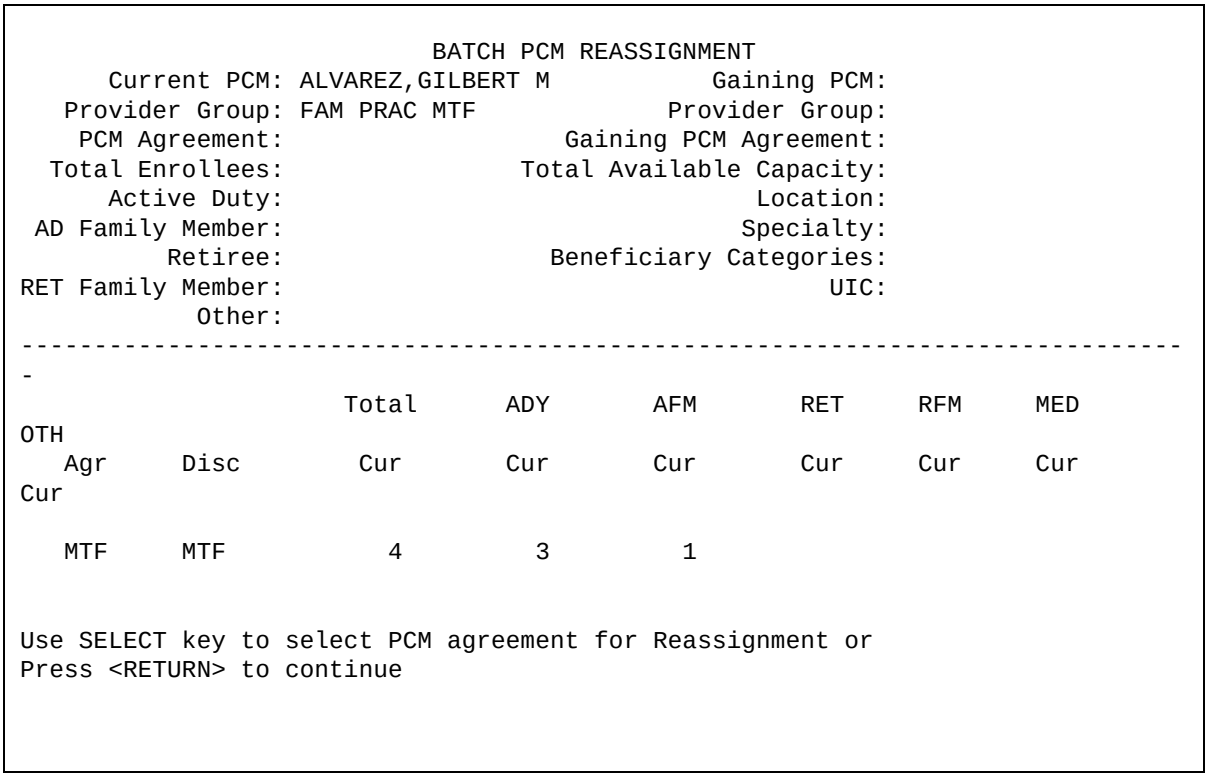


Figure 5-132. Batch PCM Reassignment Screen - With Data

1. Position cursor next to PCM agreement and press <Select>.

The beneficiary categories you select appear in the top Display Window. Search by beneficiary category to find a valid PCM agreement with a sufficient capacity to accommodate all patients of the beneficiary category selected. You may select one or multiple beneficiary categories for reassignment from the current PCM. Multiple beneficiary categories may limit the resulting PCM picklist.

Select the search criteria for change (specialty, location, and agreement type)

```
                          BATCH PCM SEARCH CRITERIA
      Current PCM: ALVAREZ,GILBERT M           Gaining PCM:
   Provider Group: FAM PRAC MTF             Provider Group:
    PCM Agreement: MTF                 Gaining PCM Agreement:
  Total Enrollees: 4                Total Available Capacity:
      Active Duty: 3                               Location:
 AD Family Member: 1                             Specialty:
          Retiree:                    Beneficiary Categories: ADY
RET Family Member:                                    UIC:
          Medicare:
            Other:

   Specialty
   Location
   Agreement Type
   Default Search Criteria


                       Specialty and Location are Required
Use SELECT key to select SEARCH CRITERIA to be changed
```

Figure 5-133. Batch PCM Search Criteria Screen

1. Specialty

2. Location

   This is the location by ZIP code(s) in which to search for the Gaining PCM. Enter one or more ZIP codes consisting of 3 to 5 digits. The system searches for locations using the 3rd, 4th, or 5th digits. You may enter up to five ZIP codes in this field. Separate each ZIP code by a comma.

   You may also enter the name of a ZIP code combination instead of entering separate ZIP codes. A ZIP code combination is the identifier defined in the ZIP Code Combination file. It lists a logical grouping of ZIP codes. For example, the ZIP code combination DC AREA would include all the ZIP codes for the Washington, D.C. area.

3. Agreement Type

   This searches for a gaining PCM by agreement type. If an agreement type is not specified, the system searches for a gaining PCM with any PCM agreement, regardless of its type.

The message, *"Searching..."* displays while the system searches for the appropriate PCMs.

If a provider has multiple specialties and multiple places of care, that provider is listed multiple times, once for each combination. Refer to Figure 5-134. Batch PCM Reassignment Screen, page 5-261.

Certification Specialty (CS) - The level of Board Certification the provider holds for this specialty. Valid codes are:

Blank	Not Certified
E	Board Eligible
BO	Board Certified
NA	National Certification

Provider Category (Cat) - The professional level of the provider, for example, MD = Physician, NP = Nurse Practitioner, PA=Physician Assistant, etc.

Provider Specialty (Specialty)

Agreement Type (Agr)

Location (Locat) - Individual ZIP code of the PCM's Place of Care.

Provider Gender (Sex)

Overall Discount Rate (Disc)

Total Available PCM Capacity (Avail) - The total available patient capacity for the provider.

Providers are listed in two groups. MTF providers are listed first and external providers next. Within these groups, providers are listed by discount rates in order of largest to smallest. Finally, within each set of rates, the order is by ZIP code. In the Disc column, MTF providers are designated by "MTF" instead of by an actual discount percentage value.

PCM Screening - The total available PCM capacity must be sufficient to accommodate the patients being reassigned from the current PCM. The system does not display PCMs with insufficient capacity to accept the patients. They also may not display due to inactive agreements, search criteria, if the other provider's agreement plan does not accept the patient type, or the other provider is not specified as a PCM. Refer to Figure 5-134. Batch PCM Reassignment Screen, page 5-261.

```
                            BATCH PCM REASSIGNMENT
      Current PCM: ALVAREZ,GILBERT M           Gaining PCM:
   Provider Group: FAM PRAC MTF             Provider Group:
    PCM Agreement: MTF                Gaining PCM Agreement:
  Total Enrollees: 4               Total Available Capacity:
      Active Duty: 3                               Location: ARLINGTON
 AD Family Member: 1                             Specialty: FAMILY
PRACTICE/PRIM
          Retiree:                    Beneficiary Categories: ADY
RET Family Member:                                     UIC:
        MEDICARE:
            Other:
--------------------------------------------------------------------------------
-
   Provider               CS Cat   Specialty        Agr Locat Sex Disc    Avail
--------------------------------------------------------------------------------
-
   ARRIBA,GILBERT M       E  MD    FAMILY PRACTICE  MTF 20301  M  MTF       496
   BEALE,SHARON M         B  MD    FAMILY PRACTICE  MTF 20301  F  MTF       496
   CRAWFORD,KYLE M           NPC   PRIMARY CARE NUR MTF 20301  M  MTF       497
   DELL,ALICE M              MD    FAMILY PRACTICE  MTF 20301  F  MTF       500
   EDROZO,FRANK M            NPC   PRIMARY CARE NUR MTF 20301  M  MTF       499

--------------------------------------------------------------------------------
-
Use SELECT key to select gaining PCM to be assigned
Press F9 key to view Assignment Preferences, Place of Care, or Watch Codes
```

Figure 5-134. Batch PCM Reassignment Screen

Select the gaining PCM

In some cases, the gaining PCM may have a total available PCM capacity that is less than the current PCM's number of total enrollees. This is acceptable as long as the gaining PCM has sufficient capacity both overall and in the designated beneficiary category to accommodate all patients (by beneficiary category) previously selected for reassignment.

1. Select the gaining PCM.

   If you select a provider with an agreement type that differs from that of the current PCM, the message - This is a change in Agreement Type. Continue with Reassignment? No// - displays. You may confirm the selection and continue, or choose not to continue and return to the provider list to make another selection.

   Similarly, if you select a provider with an overall discount rate that differs from that of the current PCM, the message - This is a change in Discount Rate. Continue with Reassignment? No// - displays. Confirm the change or exit the reassignment process.

2. Confirm the PCM assignment.

3. Change Assignment Reason.

4. After entering a reason, the reassignment process is sent to TaskMan to be processed as time permits.

5. The request is processed and the Batch PCM Reassignment Menu displays.

6. After the reassignment process completes, you receive a bulletin indicating the completed reassignment. The bulletin is also sent to the mail group BATCH PCM.

   Refer to Section 2.4 File Table and Building and Maintenance for information concerning mail bulletins. This section describes the menu path, business rules, and specific bulletins associated with mail bulletins.

CHCS will set the enrolling DMIS ID to the new PCM's place of care Division DMIS ID. CHCS will transmit any changes in DMIS ID to DEERS to maintain synchronization.

Note: You should also run the PCM Reassignment Report to:

Ensure that no discrepancies were found during the reassignment process.

Check if any appointments with the prior PCM should be canceled and rescheduled with the gaining PCM.

5.12.2 Family PCM Reassignment

Menu Path: PAS System Menu → M → BMCP → FPCM

- **Required Fields**

  Patient Name
  Specialty
  Location
  Gaining PCM
  Assignment Reason
  Report Family Appointment action.

- **Application Description**

The Family PCM Reassignment option allows you to reassign all or some of the enrolled members of a family to a new PCM. You enter the name of the patient, and specify which members of the patient's family are to be reassigned. You may assign a new PCM directly, or specify search criteria, and select the new PCM from the list of those who meet the search criteria. If reassigned family members have appointments booked with their prior PCM, a report of those appointments are generated.

Family PCM Reassignment changes the patients' enrolling divisions if the new PCM practices in a location different from the previous PCM.

Reassign family members to a new Primary Care Manager (PCM)

- **Data Entry Process**

Access the Family PCM Reassignment option on the Batch PCM Reassignment Menu

Select the patient name

Select family members for reassignment

Select search criteria for change (specialty, location)

Select the gaining PCM

The user must select the Patient action to begin. Refer to Figure 5-135. Family PCM Reassignment Screen, page 5-264.

Access the Family PCM Reassignment option on the Batch PCM Reassignment Menu

```
                          FAMILY PCM REASSIGNMENT
       Patient:                                  FMP/SSN:
     Specialty:                                      DDS:
      Location:                                Gaining PCM:
 Agreement Type:                             Provider Group:
--------------------------------------------------------------------------------
-


--------------------------------------------------------------------------------
-
Select (P)atient, or (Q)uit: P//
```

Figure 5-135. Family PCM Reassignment Screen

Select the patient name

1. Enter patient name.

2. Confirm the patient name.

   The Demographics Display screen displays. Refer to Figure 5-136. Demographics Display Screen, page 5-265.

```
                            DEMOGRAPHICS DISPLAY
                  Name: PLAYER,SCOTT E               FMP/SSN: 20/572-69-4719
      Patient Category: USAF ACTIVE DUTY                 DDS:
          Patient Type: MCP/ACTIVE DUTY                  Sex: MALE
            MCP Status: ENROLLED                      DOB/Age: 07 Oct 1969/31Y
                   ACV: A-ACTIVE DUTY/MCP ENROLLED    DMIS ID: 0037
           Direct Care: ELIGIBLE                     Medicare:

          Sponsor Name: PLAYER,SCOTT E                    Rank: AIRMAN
          Station/Unit: 0009 AIR POSTAL         SQ         DSN:
          Home Address: 728 NORTH STAR RD
                  City: MC LEAN                         State: VIRGINIA
              ZIP Code: 22101                     Home Phone: 703-555-9739
            Duty Phone: 202-555-4567              Work Phone: 202-555-4567
 Registration Comment:
Last Registration Date: 09 Sep 1999@1621
Outpatient Record Room: OUTPATIENT RECORDS
       MCP Enroll Date: 20 Jun 2001          End Enroll Date: 10 Feb 2003
 Primary Care Manager: CHUNG,KYLE M               PCM Phone: 202 271-5850
           Primary OHI: NOT ASSIGNED               Case Mgmt: NO

Select (F)ull, (M)ini, (N)ew Patient, (C)ontinue, or (Q)uit DEMOGRAPHICS: C//
```

Figure 5-136. Demographics Display Screen

3. Press <Return> to accept the (C)ontinue action.

   The Family PCM Reassignment screen displays. Refer to Figure 5-137. Family PCM Reassignment Screen, page 5-266.

The top Display Window displays the following fields:

Demographic Data

Patient
FMP/SSN
DDS - DEERS Dependent Suffix

Search Criteria

Specialty - Provider specialty required
Location - Preferred Provider Location

Agreement Type - Provider Agreement Type

Gaining PCM Criteria

Gaining PCM
Provider Group - Gaining PCM group

The middle Select Window displays all family members associated with your patient. For each family member, the list also displays:

FMP/SSN
Current PCM

Enrollment Status - The valid enrollment statuses are:

C	Conditional
IE	Invalid Enrollment
E	Enrolled
D	Disenrolled
ID	Invalid Disenrollment
Not Enrolled.	

```
                          FAMILY PCM REASSIGNMENT
       Patient: PLAYER,SCOTT E                  FMP/SSN: 20/572-69-4719
     Specialty:                                     DDS:
      Location:                              Gaining PCM:
 Agreement Type:                          Provider Group:
--------------------------------------------------------------------------------
   Family Member                     FMP/SSN         Current PCM      Enr Status

   PLAYER,STEVEN E                   01/572-69-4719  CHUNG,KYLE M            E
   PLAYER,SCOTT E                    20/572-69-4719  CHUNG,KYLE M            E
   PLAYER,SARAH E                    30/572-69-4719  CHUNG,KYLE M            E
--------------------------------------------------------------------------------
Use SELECT key to select family members
```

Figure 5-137. Family PCM Reassignment Screen

Select family members for reassignment

1. Select all family members for reassignment

2. Select the Reassign Family PCM action

3. Select the Change Search Criteria action

The following search parameters are listed in the middle Select Window:

Specialty
Location
Agreement Type
Default Search Criteria

A specialty and location are required.

Select search criteria for change (specialty, location)

The following search parameters are available.

1. Specialty

2. Location

   This is the location by ZIP code(s) in which to search for the gaining PCM. Enter one or more ZIP codes consisting of 3 to 5 digits. You may enter up to five ZIP codes at this prompt. Separate each ZIP code by a comma.

   You may also enter the name of a ZIP code combination instead of entering separate ZIP codes.

Select the gaining PCM

After all the selected search criteria have been entered, the Family PCM Reassignment screen is displayed. The Search PCM action has been added to the PCM action bar.

1. Press <Return> to accept the Search PCM action. The Family PCM Reassignment screen displays.

   The middle Select Window displays a list of the PCMs who meet the search criteria specified. For each Provider, the list also displays the following information:

Certification Specialty (CS) - Indicates the level of Board Certification the provider holds for this specialty. Valid codes are:

Blank	Not Certified
E	Board Eligible
BO	Board Certified
NA	National Certification

Provider Specialty (Specialty)
Agreement Type (Agr)
Overall Discount Rate (Disc)

Total Available PCM Capacity (Avail) - Indicates the total available patient capacity for the provider. The system ensures that each PCM has sufficient capacity for the selected family members.

MTF providers display first, followed by providers listed in order of largest to smallest overall discount rate. MTF providers are designated by “MTF” displayed in the Discount field, instead of an actual discount percentage value.

1. Select the gaining PCM.

2. Select Assignment Reason.

   The reason abbreviation, GR, indicates that the patient is dissatisfied or has a grievance with the current PCM. An assignment reason must exist in the Assignment Reason file to be valid. You may enter additional assignment reasons to the Assignment Reason file by accessing the PCM Assignment Reason Enter/Edit (PCMA) option.

   After entering a reason, the reassignment process begins. The name of each reassigned patient displays at the bottom of the screen and you are informed when the reassignment process is complete.

3. After the reassignment completes, the system checks each reassigned family member for pending appointments with the prior PCM. If pending appointments exist, the Report Family Appointments action displays. This report lists any pending appointments with the prior PCM that may need to be rescheduled with the gaining PCM. Select the Report Family Appt action.

4. Select DEVICE.

   The Family Appointments with a Prior PCM screen displays. Refer to Figure 5-138. Family Appointments with a Prior PCM Screen, page 5-269. The report lists all family members that have prior primary care appointments with the losing PCM.

```
                Personal Data - Privacy Act of 1974 (PL 93-579)          Page
1
                      FAMILY APPOINTMENTS WITH A PRIOR PCM
Sponsor:  PLAYER,SCOTT E                                  Family SSN: 572-69-
4719
================================================================================
=
       New PCM: FONTANA,LUISA M                          Agreement Type: MTF
Provider Group: FAM PRAC MTF                              Discount Rate: 0
--------------------------------------------------------------------------------
-
Patient                           FMP  Home Phone            Appt Date/Time
                                       Work Phone            Provider
================================================================================
=

PLAYER,SARAH E                    30   H: 703-555-9739       10 Jul 2001@0800
                                       W:                    CHUNG,KYLE M

PLAYER,SCOTT E                    20   H: 703-555-9739       10 Jul 2001@0800
                                       W: 202-555-4567       CHUNG,KYLE M

PLAYER,STEVEN E                   01   H: 703-555-9739       10 Jul 2001@0830
                                       W:                    CHUNG,KYLE M


Press <RETURN> to continue
```

Figure 5-138. Family Appointments with a Prior PCM Screen

CHCS will set the enrolling DMIS ID to the new PCM's place of care Division DMIS ID. CHCS will transmit any changes in DMIS ID to DEERS to maintain synchronization.

5.12.3 Active Duty Enrollee UIC Maintenance Report

Menu Path: PAS System Menu → M → BMCP → APCM → URPT

PART I

- **Contents**

This report shows, by enrolling division, those active duty beneficiaries whose unit of assignment has changed. The report shows the following for comparison:

– The former unit name and the patient's current PCM

– The new unit name and the PCM who is currently assigned to that unit.

- **Use/Frequency**

This report should be run at least weekly. This report should be used to identify those active duty beneficiaries whose PCM may need to be changed due to a change in unit assignment or because they left the area.

- **Special Instructions**

If an active duty member's unit of assignment has changed to a new unit in the area, their PCM may need to be changed also (if PCMs are assigned locally according to unit of assignment). If the PCM is changed, a corrected enrollment ID card should be issued by the user with the new PCM name.

On the other hand a new unit of assignment may indicate that the beneficiary has moved to another area. If so, the beneficiary will need to be monitored by the user. The user must determine (according to Service policy) whether a reciprocal disenrollment is issued by the gaining site within a reasonable time so that the local PCM slot is freed up. Policy must be developed locally by the sites on the procedures to follow if the gaining site does not issue a reciprocal disenrollment within a reasonable amount of time.

PART II

- **Contents**

The second part of this report lists beneficiaries with UICs that are not standard values in the UIC table. These beneficiaries could have left the area and may need to be disenrolled.

- **Use/Frequency**

See above guidance in Part I for frequency. This report should be used to identify those active duty beneficiaries with an invalid or non-standard UIC.

- **Special Instructions**

Refer to correction procedures in Part I above. The active duty member's UIC may need to be corrected to a standard value if the correct value is available in the CHCS UIC table. If the UIC is a correct value but is not in the table, a customer support call should be initiated to request that that value be included in the UIC table in the future.

- **Report Sample**

Refer to Figure 5-139. Active Duty Enrollee/UIC Maintenance Report, page 5-271.

```
NMC  PORTSMOUTH VA                                    09 Mar 1994@1451    Page
1
                     ACTIVE DUTY ENROLLEE/UIC MAINTENANCE REPORT
                  Part 1:  Active Duty Enrollees with a Change in UIC Code
Enrolling Division: MCDONALD (EUSTIS)
================================================================================
=
Name                                      Old UIC
   FMP/SSN            Current PCM                 Agr  Specialty
   New UIC            Default PCM                 Agr  Avail AD Capacity
--------------------------------------------------------------------------------
-
BAILEY,HAROLD                             1912 COMMUNICATION
 20/359-46-8955       FAMILY PRACTICE LAFB          MTF  FAMILY PRACTICE P
 1 TFS                FLIGHT MEDICINE LAFB          MTF       UNL

DE BLASIO,MICHAEL                         1 CRS
 20/234-50-5467       MERCER,MICHAEL                MTF  INTERNIST
 1 MED                DEL CARMEN,RICHARD            MTF       376

EISCHING,ELAINE B                         1EMS
 20/432-44-5487       FAMILY PRACTICE LAFB          MTF  FAMILY PRACTICE P
 1 CRS                HARRIS,SCOTT                  MTF        0

--------------------------------------------------------------------------------
-
Footnote: Enrollee records have been updated with a new UIC code. The user must
determine if a change in PCM is appropriate.

NMC  PORTSMOUTH VA                                    09 Mar 1994@1451    Page
```

```
2
                      ACTIVE DUTY ENROLLEE/UIC MAINTENANCE REPORT
                  Part 2:  Active Duty Enrollees with invalid UIC Codes
Enrolling Division: MCDONALD (EUSTIS)
================================================================================
=
   FMP/SSN   Name   UIC Code
--------------------------------------------------------------------------------
-
 20/234-54-7465    SANTOS,MERVIN       Langley
 20/432-44-3645    TJERNAGEL,STEVEN A  1st Medical
```

Figure 5-139. Active Duty Enrollee/UIC Maintenance Report

Section 6 Managing MCP Patient Appointments

6. MANAGING MCP PATIENT APPOINTMENTS

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Introduction

This section covers:

- Options used to book primary care appointments and specialty care for both enrolled and non-enrolled patients.
- How to display or print a patient's appointments.
- How to document a patient's refusal of an appointment.
- How to cancel an appointment at a patient's request.
- How to generate appointment referral products (i.e., enrollment forms, membership ID, and patient labels), and includes samples of the output products.
- Reports on the Health Care Finder Menu and includes samples of each.

6.1 The Health Care Finder Menu (HMCP)

Menu Path: PAS System Menu → M → HMCP

- **Security Keys**

  CPZ CCP
  CPZ OHI*
  CPZ CASE**
  CPZ NAS***

* Only needed by users entering other health insurance (OHI).
** Only needed by users booking case management appointments.
*** Only needed by users issuing Non-Availability Statements (NASs).

- **Application Description**

The following capabilities represent support provided by the CHCS MCP Health Care Finder module to the TRICARE program.

1. **Referral Tracking**

   - Collects data that can be used to identify primary care manager (PCM) referral trends (by specialty, geographic area, International Classification of Diseases (ICD-9), Current Procedural Terminology (CPT-4), and so on).

- Collects data on the type of care the contractor PCMs are referring into the direct care system and the frequency.

- Tracks patient requirements against actual booked appointment.

- Support documentation of pre-authorization of care.

2. Improved Eligibility Checking

- Performs eligibility checks required for each appointment. CHCS identifies ineligible beneficiaries in real time before the appointment is made. Appointments for ineligible beneficiaries do not need to be retroactively canceled as required in Patient Appointment and Scheduling (PAS).

- Allows you to override ineligibility and book the appointment. The system documents the override.

3. Workload Tracking

- Breaks out enrollee versus non-enrollee appointing trends.

4. Access Tracking

- Tracks outpatient access by high-level categories of patient access requirements (i.e., 24 hours, 48 hours, 72 hours, emergency, routine).

- Assesses distance traveled to see provider based on ZIP Code of residence or work versus ZIP Code of place of care.

Booking Primary Care Appointments - Three options on the MCP menus are used for booking primary care appointments: the PCM Booking (PHCF) option and the Non-Enrolled Booking (NHCF) option on the Health Care Finder Menu, and the Non-Enrolled Booking (NMCP) option on the Managed Care Program Menu. The NHCF and NMCP options are identical.

Three types of booking are available:

- **PCM Booking** - Allows you to book only enrolled patients with their assigned PCM.

- **Non-Enrolled Booking** - Allows you to book appointments with network and non-network providers for patients who are not currently enrolled in TRICARE, who are conditionally or pending enrolled, and who have invalid enrollments. The Non-Enrolled Booking option is also on the Managed Care Program Menu.

– **Referral Booking** - Allows you to enter or edit an appointment referral for specialty care for an enrolled or non-enrolled patient and book one or more appointments for the patient with network or non-network providers as a result of the referral.

6.1.1 PCM Booking (PHCF)

Menu Path: PAS System Menu → M → HMCP → PHCF

- **Security Keys**

  CPZ CCP needed by all MCP users. No other security keys required to access this option.

- **Required Fields**

  Patient name
  Appointment type
  Specialty
  Time range
  Days of week
  Duration

- **Application Description**

The PCM Booking option allows you to book appointments for patients with their PCM. This option can be used *only for patients who are enrolled in TRICARE*. If the patient does not yet have an assigned PCM, you must assign one before you can book an appointment. You can also enter an appointment refusal and view appointment refusal history for the patient being processed.

> **Note**: Appointments for non-enrolled, pending enrolled, and conditionally enrolled patients must be booked using the Non-Enrolled Booking (NHCF) option.

When you have finished processing a patient, you can select another patient name for processing or exit the option.

- **Business Rules**

– PCMs must be members of the MCP network and designated as an individual provider, a group practice, medical treatment facility (MTF) clinic, or a civilian institution.

– Individual MTF providers generally have schedules in CHCS; however, group MTF providers may not. Refer to Table 6-1. Appointment Searches for MTF Group Providers Acting as PCM, page 6-5.

– If a patient's eligibility has changed, a warning message displays instructing the patient to disenroll from the old entitlement in order to enroll in the new entitlement.

> Note: Users with the proper access can create schedules for clinics that have been designated as PCMs using the PAS Create Schedules option. Menu Path: PAS System Menu → Scheduling Supervisor Menu → SCHE → CSCH

Table 6-1. Appointment Searches for MTF Group Providers Acting as PCM

Has Schedules	Does Not Have Schedules	
Appointment search only displays open appointment slots for clinic.	No providers set up as individual PCMs.	Some but not all providers set up as individual PCMs
	Assumes all providers in specified clinic will act as PCMs.	Assumes only those individual providers that are set up as individual PCMs will act as PCMs in specified clinic.
	Appointment search displays ALL open appointment slots for ALL PROVIDERS in specified clinic.	Appointment search displays open appointment slots for ONLY those providers that were designated as individual PCMs.

Appointment Searches - Whenever an appointment search is initiated through the PCM Booking (PHCF) option and the patient's PCM is an MTF clinic (i.e., MTF group provider), the system first checks to determine whether the clinic has schedules for the date range specified. Refer to Table 6-1. Appointment Searches for MTF Group Providers, page 6-5.

1. **PCM is a group provider (MTF clinic) with schedules**

   If schedules exist for the specified MTF clinic the system displays ONLY available appointment slots for that specified MTF clinic.

   You may select any of the open appointment slots and book an appointment for the patient. When the patient is checked in, the clerk can enter the name of the provider within the group who saw the patient, using the End-of-Day Processing (EOD) option.

2. **PCM is a group provider (MTF clinic), no schedules, no providers set up as individual PCMs**

   If no schedules exist for the clinic but do exist for individual providers assigned to the hospital location, the system displays all available appointment slots that meet the search criteria for all those individual providers, even though these providers have not been designated as individual PCMs. The system assumes that all providers in the specified clinic will act as PCMs.

3. **PCM is a group provider (MTF Clinic), no schedules, some providers set up as individual PCMs**

   If no schedules exist for the MTF clinic designated as a PCM, but some providers assigned to this hospital location are designated as individual PCMs and these providers have schedules, the system displays ONLY the available slots for the PCMs and excludes the rest of the providers in that clinic.

4. **PCM is a group provider** (**non-MTF place of care)**

   If the PCM assigned to a patient is a non-MTF place of care, the system displays the PCM Non-MTF Booking Search Criteria screen when you quit the Demographics Display screen. The system displays the name of the group provider designated as the patient's PCM and the place of care phone number in the middle Select Window. The system also prompts you to select the PCM. You may accept the default or, after contacting the place of care, enter the name of the individual PCM who will be seeing the patient.

Once the PCM has been entered, the system redisplays the PCM Non-MTF Booking Search Criteria screen and allows you to continue processing by first creating the appointment slot, then booking the appointment.

- **Data Entry Process**

Book a patient appointment with an assigned individual PCM or group PCM with schedules

Access the PHCF option

Select the patient

Review current DEERS eligibility

Review patient demographics

Select the specialty type

Determine non-MTF or MTF booking

Select the search criteria

Search for appointment(s)

Select appointment(s)

Book the appointment(s)

File the data

Print patient's appointment(s)/Wait List requests

Continue booking appointments for the same patient or exit the option

Access the PHCF option

When you access the PHCF option, the PCM Booking Search Criteria screen displays. Refer to Figure 6-1. PCM Booking Search Criteria Screen, page 6-8. You are prompted to either enter the name of a patient or quit the option.

```
                          PCM BOOKING SEARCH CRITERIA
Patient:                                                  FMP/SSN:
Patient Type:                                             Appt Type:
Clinic:                                                   Specialty:
Clinic Phone:
Provider:                                                 Duration:
Location:                                                 Days of Week:
Dates: 21 Jun 2001 to 02 Aug 2001                         Time Range: 0001 to
2400
_____________________________________________________________________________
__



_____________________________________________________________________________
__
Select (P)atient or (Q)uit: P//
```

Figure 6-1. PCM Booking Search Criteria Screen

The PCM Booking Search Criteria screen has three windows: The top Display Window contains the patient demographic and provider fields. These fields are blank, except the Dates and Time Range fields. The middle Select Window is also blank. The bottom Interact Window contains the action bar. Only two actions are available: Select (P)atient, or (Q)uit.

Select the patient

1. Select (P)atient or (Q)uit: P//

   Press <Return> to accept the default (P)atient action on the PCM Booking Search Criteria screen.

   The *Select (P)atient or (Q)uit: P//* prompt is replaced with the *Select PATIENT NAME* prompt.

2. Select PATIENT NAME

   Enter the patient ID using your site's preferred method of patient lookup. If the patient is not registered in CHCS, the system asks you if you are adding a new patient. If you answer "Y," the system prompts you to register the patient using Mini

Registration. If you answer "N," the system returns to the *Select PATIENT NAME* prompt.

If the patient is registered, the system displays the patient's family member prefix (FMP), the sponsor's Social Security number (SSN), the patient's date of birth (DOB), sex, and rank if the patient is the sponsor, and asks you to confirm the information is correct.

3. OK? Yes//

   Verify the sponsor name. If the sponsor name is correct, press <Return>.

Review Current DEERS Eligibility

The system then performs a Defense Enrollment Eligibility Reporting System (DEERS) check or displays the Current DEERS Eligibility screen and performs a MCP CHCS/DEERS discrepancy data check. Refer to Section 4 DEERS Functions and Processes.

If a DEERS check has been performed within the past five days, the Current DEERS Eligibility screen displays. Refer to Figure 6-2. Current DEERS Eligibility Screen, page 6-10. If a DEERS eligibility check has not been performed within the last five days, a DEERS eligibility check is performed automatically. Enter an override code or quit if the patient is ineligible.

```
                          CURRENT DEERS ELIGIBILITY
                 Name: PICARD,ZACHARY E              FMP/SSN: 20/379-43-6114
   Patient Category: USA ACTIVE DUTY OFFICER         DDS: 20
            DOB/Age: 19 Feb 1966/35Y                 Sex: MALE
_____________________________________________________________________________
__
             Sponsor Rank: CAPTAIN
              Sponsor UIC: W4XEAA-RESOURCE SERVICES WASH
                  DMIS ID: 0037-WALTER REED AMC
                      ACV: A-ACTIVE DUTY/MCP ENROLLED
           ACV Start Date: 11 Mar 1999               Region Code: 02
  Care Authorization PH#: 555-2349                 PCM Location: DIRECT CARE
PC
               Direct Care: ELIGIBLE                    Medicare: NOT ELIGIBLE
Dir Care Elig Start Date: 12 Mar 2001                   CHAMPUS: NOT ELIGIBLE
  Dir Care Elig End Date: 10 Feb 2003
  Eligibility End Reason:

                                        BRAC Pharmacy Eligibility: NO
            Override Code:
          Date of Request: 17 Jun 2001
_____________________________________________________________________________
__
Select to (V)iew more DEERS data, (P)rint,(R)epeat DEERS check,(C)ontinue,
       or (Q)uit: C//
```

Figure 6-2. Current DEERS Eligibility Screen

At the Current DEERS Eligibility action bar, you can view more DEERS data, print a copy of the current DEERS eligibility data, repeat the DEERS check, continue, or quit. Refer to Section 4 DEERS Functions and Processes, for detailed information about the Current DEERS Eligibility screen.

Select to (V)iew more DEERS data, (P)rint, (R)epeat DEERS check, (C)ontinue, or (Q)uit: C//

Accept the default (C)ontinue action.

Review patient demographics

The Demographics Display screen displays, allowing you to review patient demographic and enrollment data and select the next option. Refer to Figure 6-3. Demographics Display Screen, page 6-11.

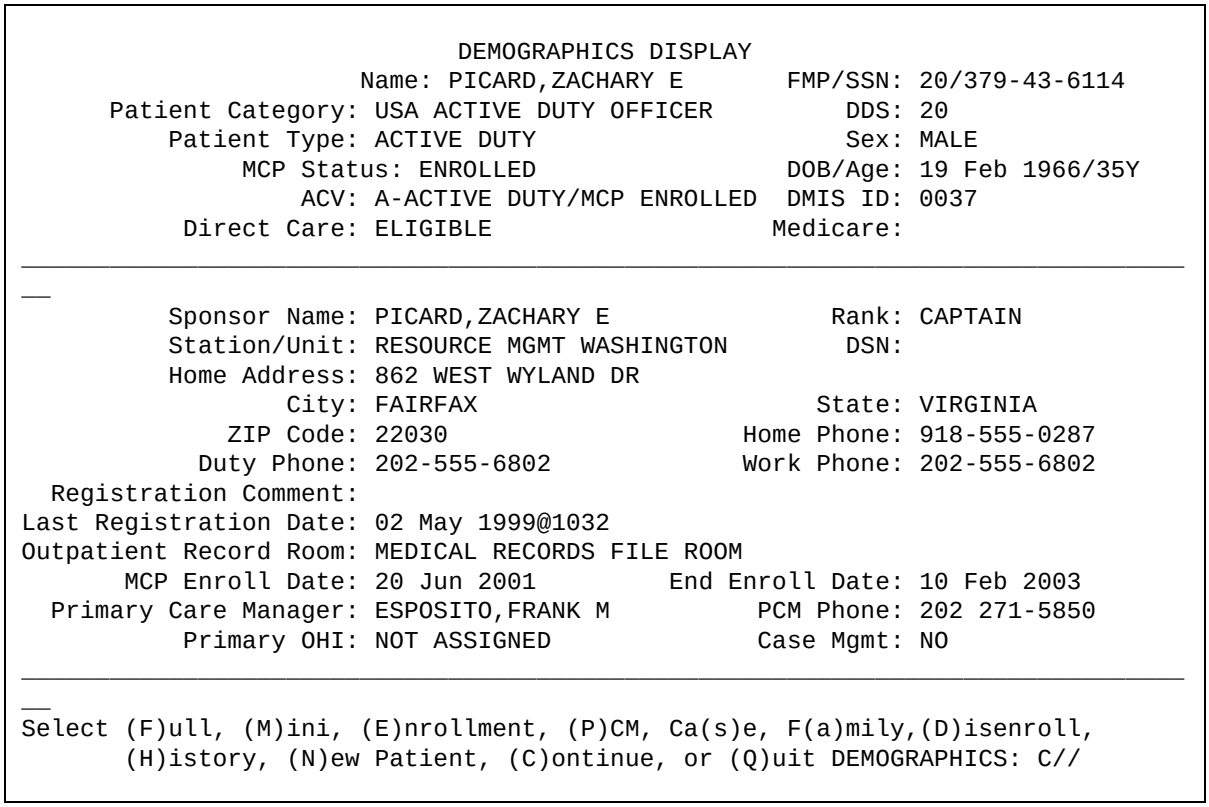

Figure 6-3. Demographics Display Screen

The Demographics Display screen has three windows: The top Display Window contains the patient demographic fields. The middle Select Window displays the sponsor's name, station/unit, rank, and Defense Switching Network (DSN) number, and patient data. The bottom Interact Window contains an action bar with the following actions:

- **(F)ull = Full Registration -** Displays the Full Registration screens and allows you to edit the patient's registration. When you complete the entries, you return to the Demographics Display action bar.

- **(M)ini = Mini Registration -** Displays the Mini Registration screens and allows you to edit the appropriate fields (e.g., home address, home phone). When you complete the entries, you return to the Demographics Display action bar. Mini Registration includes one demographics data entry screen and one display-only screen containing enrollee information.

- **(E)nrollment = Enrollment Enter/Edit -** Displays the enrollment screens and allows you to enter/edit an MCP patient's enrollment. When you complete the entries, you return to the Demographics Display action bar. Anyone in HCF can do enrollments.

- **(O)HI = Other Health Insurance -** Allows you to enter/edit/view the patient's OHI information. This action does not display for Active Duty Enrolled. When you complete the entries, you return to the Demographics Display action bar. You must have the proper security key to use this action.

- **(P)CM = Primary Care Manager -** Displays the PCM Assignment screen and allows you to change the patient's PCM. When you complete the entries, you return to the Demographics Display action bar. Changing the PCM does not change the enrolling division. Use enrollment to perform this function.

- **Ca(s)e = Case Management -** Displays the Case Management screen and allows you to enter/edit exception provider information. When you complete the entries, you return to the Demographics Display action bar. This action is only available to users with the CPZ CASE security key.

- **F(a)mily = Family Member Enrollment -** Displays the Family Enrollment screen and allows you to enroll family member(s). When you complete the entries, you return to the Demographics Display action bar.

- **(D)isenroll = Disenrollment from MCP -** Displays the Disenrollment screen and allows you to disenroll the patient from MCP. Upon completion, you return to the Demographics Display action bar.

- **(H)istory = View/Print Enrollment History -** Displays the Enrollment History screen and allows you to print/view the patient's enrollment history. When you finish viewing or printing, you return to the Demographics Display action bar.

- **(N)ew Patient = Selection of another patient -** Returns to the *SELECT PATIENT* prompt and allows you to select a different patient for processing. Processing of the initial patient terminates when a new patient is selected from the Demographics Display action bar.

- **(C)ontinue -** Displays the PCM Booking Search Criteria screen if you are in PCM Booking, or the Appointment Referral Booking screen if you are in Appointment Referral Booking.

- **(Q)uit Demographics -** Quits the Demographics action bar and returns to the *Select (P)atient, or (Q)uit* prompt (the first step in this option).

Note: If the patient category (PATCAT) or DOB is missing from the registration data for this patient when you select the Quit action, a message informs you that this information is missing. Select either Full or Mini Registration to enter the missing information.

If the patient is not enrolled in MCP, a message and action bar for non-enrolled patient display on the Demographics Display screen. Refer to Figure 6-4. Demographics Display Message and Action Bar for Non-Enrolled Patient, page 6-13. Only network providers can be designated as PCMs, and the patient must have an MCP status of Enrolled before you can continue.

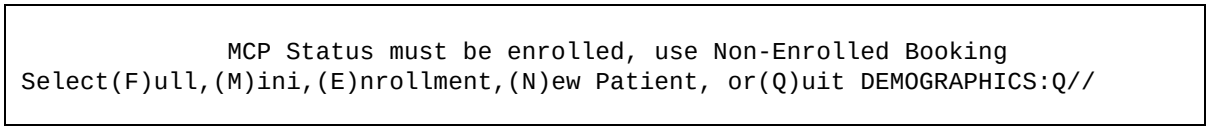

Figure 6-4. Demographics Display Message and Action Bar for Non-Enrolled Patient

Accept the default (C)ontinue action on the Demographics Display screen. Refer to Figure 6-3. Demographics Display Screen, page 6-11.

Select the specialty type

When you accept the default (C)ontinue action, the PCM Booking Search Criteria screen displays. Refer to Figure 6-5. PCM Booking Search Criteria Screen, page 6-14.

```
                          PCM BOOKING SEARCH CRITERIA
Patient: PICARD,ZACHARY E                          FMP/SSN: 20/379-43-6114
Patient Type: MCP/ACTIVE DUTY                    Appt Type:
Clinic: FAM PRAC MTF/DIVA                        Specialty:
Clinic Phone: 202 271-5850
Provider: ESPOSITO,FRANK M                        Duration:
Location:                                      Days of Week:
Dates: 21 Jun 2001 to 02 Aug 2001                Time Range: 0001 to 2400
_____________________________________________________________________________
__
   FAMILY PRACTICE/PRIMARY CARE
   NURSING
   PRIMARY CARE NURSE PRACTITIONER QUALIFIED



_____________________________________________________________________________
__
Select one of the Specialty Types that contains the assigned PCM's
Provider Specialty of PRIMARY CARE NURSE PRACTITIONER QUALIFIED
```

Figure 6-5. PCM Booking Search Criteria Screen

Use the down-arrow key to position the cursor on the PCM specialty type linked to the assigned PCM. Press <Select>, then <Return>.

Determine non-MTF or MTF booking

The type of PCM assigned to the patient determines the next screen:

- **Non-MTF PCM -** The PCM Non-MTF Booking Search Criteria screen displays with an action bar prompting you to change the search criteria, enter an appointment refusal, book a single patient, or quit and return to the *Select Patient or Quit* action bar.
- **MTF PCM -** The PCM MTF Booking Search Criteria screen displays. Refer to Figure 6-6. PCM MTF Booking Search Criteria Screen, page 6-15.

The PCM Non-MTF Booking Search Criteria and the PCM MTF Booking Search Criteria screens are identical except for the heading.

Enter the specialty and preferred location of the PCM to locate appropriate PCM candidates.

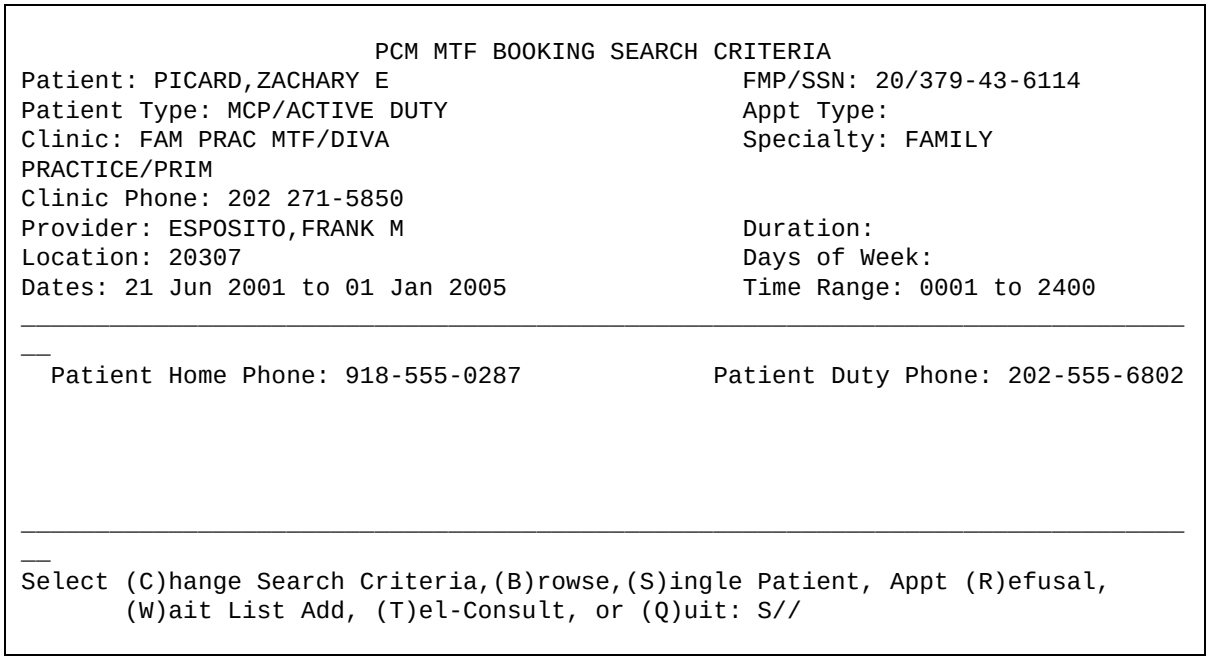

Figure 6-6. PCM MTF Booking Search Criteria Screen

The PCM MTF Booking Search Criteria screen has three windows. The top Display Window contains the same information as the Display Window of the PCM Booking Search Criteria screen. Refer to Figure 6-5. PCM Booking Search Criteria Screen, page 6-14. The middle Select Window shows the patient's home phone number and duty phone if the patient is active duty. The bottom Interact Window contains an action bar with the following actions:

- **(C)hange Search Criteria -** Allows you to select search criteria in order to narrow the search for an available appointment slot.

> **Note:** The most common and easiest method of booking an appointment with a PCM is to accept the default of (S)ingle patient rather than (C)hanging the search criteria. Refer to Figure 6-6. PCM MTF Booking Search Criteria Screen, page 6-15. The top Display Window contains defaulted search criteria for this patient's PCM. By accepting the PCM's default, CHCS accesses the screen. Refer to Figure 6-9. Filled-In PCM MTF Booking Search Criteria screen, page 6-19. If you need to change the search criteria, you can narrow or expand the search by editing the defaulted information.

- **(B)rowse -** Searches the schedule of the specified provider for a specific day to locate and display bookable appointment slots. This option cannot be used if the group is the PCM and individual providers are PCMs. If the PCM is an individual, you may overbook or join appointment slots.

- **(S)ingle Patient -** Searches for available appointments based on the search criteria entered or defaulted from the patient's PCM.

- **Appt (R)efusal** - Enters an appointment refusal without searching for an open appointment slot. Appointment refusals can also be documented using the Non-Enrolled Booking Appointment (NHCF) option, Referral Booking, or using the Enter Appointment Refusals (EHCF) option. Refer to Section 6.1.3 Appointment Referral Booking (AHCF), page 6-44, for details.

- **(W)ait List Add -** Places this patient on the Wait List for the specified MTF clinic. This action is only available if the specified clinic maintains an active Wait List.

- **(T)el-Consult -** Documents a telephone call from a patient who calls a HCF to leave a message for a provider with whom they have a booked or pending appointment.

- **(Q)uit -** Quits the PCM MTF Booking Search Criteria screen and returns to the Health Care Finder Menu.

Select the search criteria

When you choose the (C)hange Search Criteria action on either the PCM MTF Book Search Criteria screen or the PCM Non-MTF Booking Search Criteria screen, a list of search criteria displays in the middle Select Window. Refer to Figure 6-7. PCM MTF Booking Search Criteria Screen with Selectable Search Criteria, page 6-17. You can identify appointment search criteria for the enrollee's PCM.

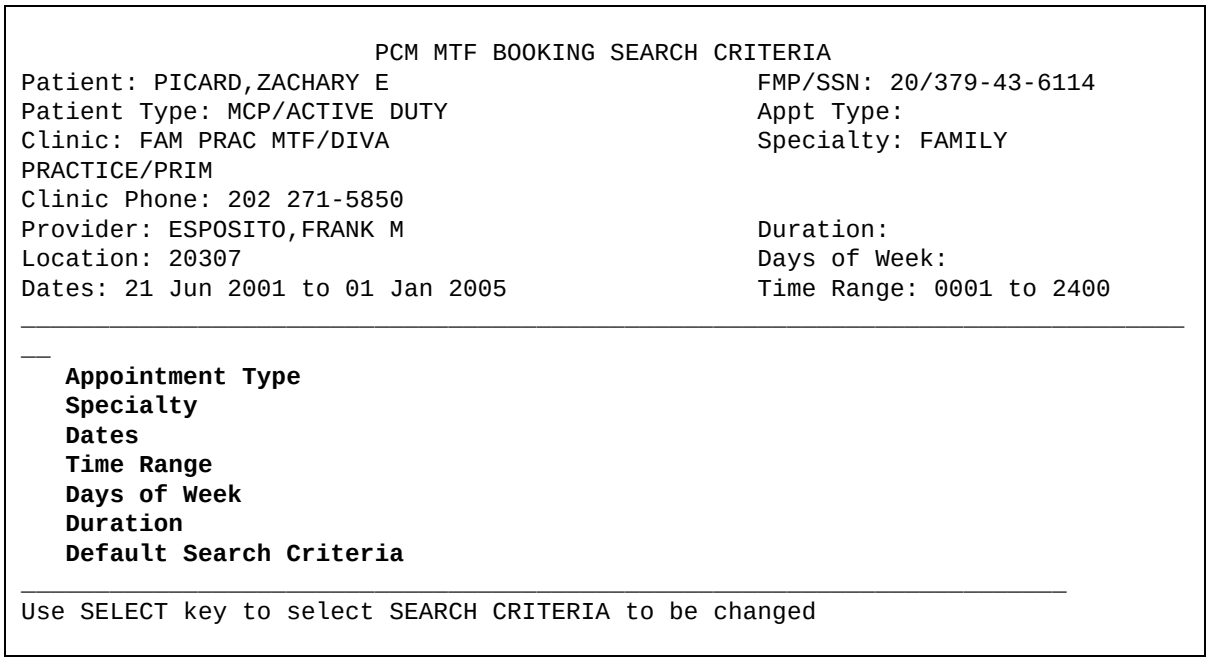

Figure 6-7. PCM MTF Booking Search Criteria Screen with Selectable Search Criteria

Use the down-arrow key to position the cursor next to the search criteria you want to change, then press <Select>. An asterisk (*) displays beside each item you select. You can deselect an item by positioning the cursor on the asterisk and pressing <Select> again. When you have made your selection(s), press <Return>. The system then prompts you to enter data for the search criteria you selected in the following order:

1. Specialty

   The PCM's specialties display again. Refer to Figure 6-5. PCM Booking Search Criteria Screen, page 6-14. When you have selected the specialty required, you are prompted for the remaining selected search criteria.

2. Dates

   Enter appointment start and stop dates. You can use these criteria to limit your search to a specific range of days. For example, if the patient needs an appointment approximately 30 days from today, you can enter T+30 as the start date and T+37 as the stop date. The system only searches for open appointments during a seven-day period beginning 30 days from today.

   The default start date is always today's date and the default stop date is always six weeks from today's date. You can change the start date to any date in the future and

the stop date to any date in the future as long as the stop date you enter is later than the start date.

3. Time Range

   Enter inclusive earliest time and inclusive latest time. You can use these two criteria to limit your search to a specific time of day. For example, your patient may ask for an afternoon appointment. For this patient, you might enter 1300 as the inclusive earliest time and 1700 as the inclusive latest time. Then the system only searches for open appointments between the hours of 1:00 and 5:00 p.m..

   The default inclusive earliest time is 0001. The default inclusive latest time is 2400.

4. Days of the Week

   Select the acceptable days of the week. A prompt displays when you choose days of the week as a search criterion. Refer to Figure 6-8. Prompt to Select Acceptable Days of the Week for an Appointment, page 6-18.

```
Select acceptable days of the week with an "X".  Press "Space Bar" to remove an
entry.  Enter "^" to accept all entries.  Use the Return and/or

Backspace keys to position the cursor on a specific day.

M:X  TU:X  W:X  TH:X  F:X  SA:X  SU:X
```

Figure 6-8. Prompt to Select Acceptable Days of the Week for an Appointment

   Select this criterion for change if your patient needs the appointment on a specific day(s). For example, the patient's day off is Wednesday. If you delete the Xs from all but "W," the system only searches for open appointments on Wednesdays.

5. Duration

   Enter the appointment's required duration, that is, the number of minutes required for the appointment as a one- to three-digit number.

6. Appt Type

   Enter a double question mark (??) at this prompt to view the appointment types available for the PCM (e.g., new or followup). You can only select from appointment types previously entered in the PCM profile.

7. Default Selection Criteria

   After you select all search criteria, the system asks if you want to save your selections as your default selection criteria. If you accept the “Yes” default at this prompt, the next time you need to search for an appointment, the search criteria data you just entered defaults into the top portion of the PCM MTF (Non-MTF) Booking Search Criteria screen for all patients. If you enter “N,” the search criteria fields in the top Display Window revert to the system defaults.

Search for appointment(s)

The top Display Window of the PCM MTF (Non-MTF) Booking Search Criteria screen is now filled in with the search criteria you specified. Refer to Figure 6-9. Filled-In PCM MTF Booking Search Criteria screen, page 6-19.

```
                          PCM MTF BOOKING SEARCH CRITERIA
Patient: PICARD,ZACHARY E                          FMP/SSN: 20/379-43-6114
Patient Type: MCP/ACTIVE DUTY                      Appt Type: FOLLOW UP
Clinic: FAM PRAC MTF/DIVA                          Specialty: FAMILY
PRACTICE/PRIM
Clinic Phone: 202 271-5850
Provider: ESPOSITO,FRANK M                         Duration:
Location: 20307                                    Days of Week:M W
Dates: 21 Jun 2001 to 30 Jun 2001                  Time Range: 0900 to 1700
_____________________________________________________________________________
__
  Patient Home Phone: 918-555-0287               Patient Duty Phone: 202-555-
6802



_____________________________________________________________________________
__
Select (C)hange Search Criteria, (B)rowse, (S)ingle Patient, Appt (R)efusal,
    (W)ait List Add, (T)el-Consult, or (Q)uit: S//
```

Figure 6-9. Filled-In PCM MTF Booking Search Criteria screen

Accept the default (S)ingle Patient action.

Select appointment(s)

On the PCM MTF (Non-MTF) Single Patient Booking screen, all PCM open appointments that meet your criteria display in the middle Select Window. Refer to Figure 6-10. PCM MTF Single Patient Booking Screen, page 6-20.

```
                        PCM MTF SINGLE PATIENT BOOKING
Patient: PICARD,ZACHARY E                          FMP/SSN: 20/379-43-6114
Patient Type: MCP/ACTIVE DUTY                      Appt Type: FOLLOW UP
Clinic: FAM PRAC MTF/DIVA                          Specialty: FAMILY
PRACTICE/PRIM
Clinic Phone: 202 271-5850
Provider: ESPOSITO,FRANK M                         Duration:
Location: 20307                                    Days of Week:
Dates: 21 Jun 2001 to 01 Jan 2005                  Time Range: 0001 to 2400
_____________________________________________________________________________
__
  FRI 1530 22 Jun 01 FOL    1/0
  FRI 1600 22 Jun 01 FOL    1/0
  FRI 1630 22 Jun 01 FOL    1/0
  MON 1500 25 Jun 01 FOL    1/0
  MON 1530 25 Jun 01 FOL    1/0
  MON 1600 25 Jun 01 FOL    1/0
  MON 1630 25 Jun 01 FOL    1/0
+ WED 1500 27 Jun 01 FOL    1/0
_____________________________________________________________________________
__
Use SELECT key to select appointment(s) to be booked
```

Figure 6-10. PCM MTF Single Patient Booking Screen

The day, time, open appointment date, appointment type, how many patients can be booked to the open slot, and how many patients have already been booked to that slot display on this screen. The 1/0 notation indicates one patient can be booked and zero have been booked.

A plus (+) sign beside the top or bottom appointment slot indicates additional open slots do not fit within the top Display Window. Use the up-arrow or down-arrow keys to display the hidden slots.

1. Position the cursor beside the appointment slot(s) you want to book for this patient, then press <Select>.

> **Note:** Asterisks (*) appear next to the schedule time slots you selected. You can deselect by pressing <Select> again.

2. When you have selected the appointment(s), press <Return>.

Book the appointment(s)

The File Appointment screen displays. Refer to Figure 6-11. File Appointment Screen, page 6-21.

```
                              FILE APPOINTMENT
Patient: PICARD,ZACHARY E                          FMP/SSN: 20/379-43-6114
Patient Type: MCP/ACTIVE DUTY                      Appt Type: FOLLOW UP
Clinic: FAM PRAC MTF/DIVA                          Specialty: FAMILY
PRACTICE/PRIM
Clinic Phone: 202 271-5850
Provider: ESPOSITO,FRANK M                         Duration:
Location: 20307
Days of Week:
Dates: 21 Jun 2001 to 01 Jan 2005                  Time Range: 0001 to 2400
_____________________________________________________________________________
__
   FRI 1530 22 Jun 01 FOL    1/0
   FRI 1530 30 Jun 01 FOL    1/0

 _______________________________  Select Slot #1 of 1
_______________________________
Select (B)ook appt, or (Q)uit FILE APPOINTMENT: B//
```

Figure 6-11. File Appointment Screen

The File Appointment screen has three windows:

The top Display Window contains current demographic information and search criteria for this booking search.

The middle Select Window displays the appointment slot(s) (day, time, date, type, and slot) that you selected. The first (or only) appointment slot is highlighted.

The bottom Interact Window displays the message telling you to select Slot #1 of 3 to process, and an action bar with the following available actions:

– **(B)ook -** Books the selected appointment slots.

- **(S)kip -** Skips the first (highlighted) appointment slot and moves to the next appointment slot on the list. **Note:** The Skip action only displays as a selection on the action bar if more than one appointment appears on the list.

– **(V)iew -** Displays the entire list of appointment slots selected and displayed for booking. You can override the sequential order of the picklist and select any appointment slot on

the File Appointment screen where multiple appointment slots are listed. **Note:** The View action only displays as a selection on the action bar if more than one appointment slot selection appears on the list.

– **(Q)uit FILE APPOINTMENT** - Quits the booking process and returns to the MTF (Non-MTF) Booking Search Criteria screen.

Press <Return> to accept the default (B)ook appt.

The secondary File Appointment screen displays, with the cursor positioned at the MEPRS Code field. Refer to Figure 6-12. Secondary File Appointment Screen, page 6-22.

```
PATIENT APPOINTMENT: PICARD,ZACHARY E                        FILE APPOINTMENT

                     FRI 1500 22 Jun 01 FOL    1/0
  No reminder notice will be sent. Hand-carry Radiology/Patient records.
                Clinic Message: Arrive 10 minutes early.
  Clinic/Appt Type Instructions:
               Provider Message:
Provider/Appt Type Instructions:
                Arrival Message: 10 minutes
           Registration Comment:

                     MEPRS Code: BGAZ
             Requesting Service:
                    Referred By:
           Send Reminder Notice: NO
            Appointment Comment:
         Reason for Appointment:

Ask for Help = HELP    Screen Exit = F10     File/Exit = DO    INSERT OFF
```

Figure 6-12. Secondary File Appointment Screen

The top half of the secondary File Appointment screen contains information for the patient from both the clinic and provider regarding the proposed appointment. This information is display only and cannot be edited. It includes patient name in the upper-left corner, the appointment data for the appointment being booked, and notice if time is inadequate to send a reminder notice or pull the patient's medical/radiology records.

The Clinic Message, Clinic/Appt Type Instructions, and Arrival Message fields are pulled from the Clinic Profile. The Provider Message and Provider/Appt Type Instructions fields are pulled from the provider profile. The Registration Comment field is pulled from Mini Registration.

1. MEPRS Code

Enter the correct Medical Expense and Performance Reporting System (MEPRS) code. The MEPRS code, formerly the Uniform Chart of Accounts (UCA) code, is a cost-accounting indicator. This permanent code is assigned to each clinic or location and is used to track the workload.

If the MEPRS code has been entered in the clinic profile, defaults to the MEPRS Code field. You may accept the default or override it.

If no MEPRS code has been entered in the clinic profile, the system prompts you to enter a valid MEPRS code in this field. This is a required entry, and you cannot exit the field without the entry. You can enter a double question mark (??) to display a list of valid MEPRS codes by clinic/location.

2. Requesting Service

   The system positions the cursor in this field only if "YES" has been entered in the Referral Required field for this appointment type in the specified clinic or provider profile. If set to "NO," the system bypasses this field.

   If the cursor is positioned in this field and this appointment is being made in response to a referral from another location, this field displays the MEPRS code of the referring location. You can override this default and enter a different MEPRS code.

3. Referred By

   If the Referral Requested field in the clinic profile is set to "YES," enter data in this field. Otherwise, the system bypasses this field.

4. Reminder Notice

   If the associated field in the clinic profile is set to "YES," the system allows you to enter/edit this field at the appointment level only if enough time remains before the appointment to send a reminder notice. If the associated field in the clinic profile is set to "NO," the system does not allow you to enter/edit this line.

5. Appointment Comment

   You can enter from 3 to 75 characters of additional appointment information in this free-text field.

6. Reason for Appointment

   You can enter from 3 to 75 characters of additional information about the reason for the appointment in this free-text field.

File the data

An action bar displays that allows you to file the data and exit the option, abort the process without filing, or edit. Press <Return> to accept the default file/exit action or use the right-arrow key to position the cursor on the Abort or Edit action, then press <Return>. If you choose to edit the data, the cursor returns to the MEPRS Code field.

If you choose to abort, you return to the File Appointment screen where you can reenter demographic information and search criteria.

When you choose the default to file/exit, the system displays the message, *Appointment Booked*, and returns to a blank PCM MTF Single Patient Booking screen. The *Remind patient of other appointments/Wait List requests* prompt displays.

Print Patient's Appointment(s)/Wait List Requests

The *Remind patient of other appointments/Wait List requests* prompt allows you to print a copy of the patient's appointments and Wait List requests or display the information to the screen. Refer to Figure 6-69. Display Patient Appointments, page 6-121, for a sample Display Patient Appointments screen. The printed copy is identical to the screen display.

1. Remind patients of other appointments/Wait List requests

   Press <Return> to accept the "Yes" default.

2. Device Name

3. Right Margin

   You can also display patient appointments through the Display Patient Appointments (DMCP) option. Refer to Section 6.2 Display Patient Appointments (DMCP), page 6-118, for details.

Continue booking appointments for the same patient or exit the option

1. Remind patient of other appointments/Wait List requests

   Enter "N" at the prompt. You return to the PCM MTF Booking Search Criteria screen with the same action bar. Refer to Figure 6-9. Filled-In PCM MTF Booking Search Criteria screen, page 6-19.

2. Select (C)hange Search Criteria, (B)rowse, (S)ingle Patient Appt, (R)efusal, (W)ait List Add, (T)el-Consult, or (Q)uit: S//

   At this action bar, you can continue booking appointments for the same patient.

3. Quit and return to the *Select (P)atient or (Q)uit: P//* action bar and book appointment(s) for another patient.

Book a patient appointment with an assigned group PCM without schedules

Access the PHCF option

Select the patient

Review current DEERS eligibility

Review patient demographics

Select the specialty type

Verify the patient's PCM

Select the search criteria

Search for appointment(s)

Add an appointment slot

File the data

Book the appointment(s)

File the data

Print patient's appointment(s)/Wait List requests

Continue booking or exit the option

Access the PHCF option

Select the patient

Review current DEERS eligibility

Review patient demographics

Select the specialty type

Use the down-arrow key to position the cursor on the PCM specialty linked to the assigned PCM. Press <Select>, then <Return>.

Verify the patient's PCM

After you enter the specialty type required for the patient, the system displays the PCM Non-MTF Booking Search Criteria screen and prompts you to select a PCM. The default is the patient's assigned PCM. Refer to Figure 6-13. PCM Non-MTF Booking Search Criteria Screen, page 6-27.

```
                    PCM NON-MTF BOOKING SEARCH CRITERIA
Patient: BLITON,STEVEN                          FMP/SSN: 06/278-55-5025
Patient Type: MCP/CHAMPUS ELIGIBLE              Appt Type:
Clinic: CLASSY MEDICAL CLINIC/MCPD              Specialty: FAMILY
PRACTICE/PRIM
Clinic Phone: 619-535-7116
Provider: CLASSY MEDICAL CARE                   Duration:
Location: 92128                                 Days of Week:
Dates: 17 Feb 1997 to 31 Mar 1997               Time Range: 0001 to 2400
_____________________________________________________________________________
__
  Patient Home Phone: 0012345678        Patient Duty Phone: 3423444




_____________________________________________________________________________
__
Select PCM: CLASSY MEDICAL CARE//
```

Figure 6-13. PCM Non-MTF Booking Search Criteria Screen

1. Select PCM

Press <Return> to accept the default PCM.

2. OK? Yes//

   The system echoes the PCM name and prompts you to verify that the name is correct. Press <Return> again to indicate the system has echoed the correct PCM name.

Select the search criteria

Search for appointment(s)

Press <Return> to accept the (S)ingle Patient action on the PCM Non-MTF Booking Search Criteria action bar. The system displays the Add An Appointment screen.
Refer to Figure 6-14. Add an Appointment Slot Screen, page 6-28.

```
                                ADD AN APPOINTMENT SLOT
Patient: BLITON,STEVEN                                  FMP/SSN: 06/278-55-5025
Patient Type: MCP/CHAMPUS ELIGIBLE                     Appt Type:FOL
Clinic: CLASSY MEDICAL CLINIC/MCPD                      Specialty: FAMILY CARE
Clinic Phone: 619-535-7116
Provider: CLASSY MEDICAL CARE                           Duration:
Location: 92128                                         Days of Week: M TU W TH
F
Dates: 17 Feb 1997 to 31 Mar 1997                       Time Range: 0900 to
1400
_____________________________________________________________________________
__




_____________________________________________________________________________
__
Select (A)dd appointments, or (Q)uit NON-MTF booking: A//
```

Figure 6-14. Add an Appointment Slot Screen

Select (A)dd appointments, or (Q)uit NON-MTF booking: A//

Accept the default (A)dd appointments.

Add an appointment slot

If you have telephoned the provider to get a appointment time, enter the date and time of the appointment. Refer to Figure 6-15. Add an Appointment Slot Screen with Date and Time, page 6-29.

```
                          ADD AN APPOINTMENT SLOT
Patient: BLITON,STEVEN                          FMP/SSN: 06/278-55-5025
Patient Type: MCP/CHAMPUS ELIGIBLE              Appt Type:
Clinic: CLASSY MEDICAL CLINIC/MCPD              Specialty: FAMILY
PRACTICE/PRIM
Clinic Phone: 619-535-7116
Provider: CLASSY MEDICAL CARE                   Duration:
Location: 92128                                 Days of Week: M TU W TH F SU
Dates: 17 Feb 1997 to 31 Mar 1997               Time Range: 0900 to 1400
_____________________________________________________________________________
__
 20Feb@0900        <---Enter appointment date@time




_____________________________________________________________________________
__
Enter appointment date@time to be added to the provider's schedule or
Press <RETURN> to continue.
```

Figure 6-15. Add an Appointment Slot Screen with Date and Time

Press <Return> after you enter the appointment date and time. If you leave out the year, the system assumes the current year.

The system displays the Non-MTF Booking - Add screen with the cursor positioned at the Appointment Type field. Refer to Figure 6-16. Non-MTF Booking - Add Screen, page 6-30. The Non-MTF Booking - Add screen has one window. Note that the provider, Classy Medical Care, is a group provider.

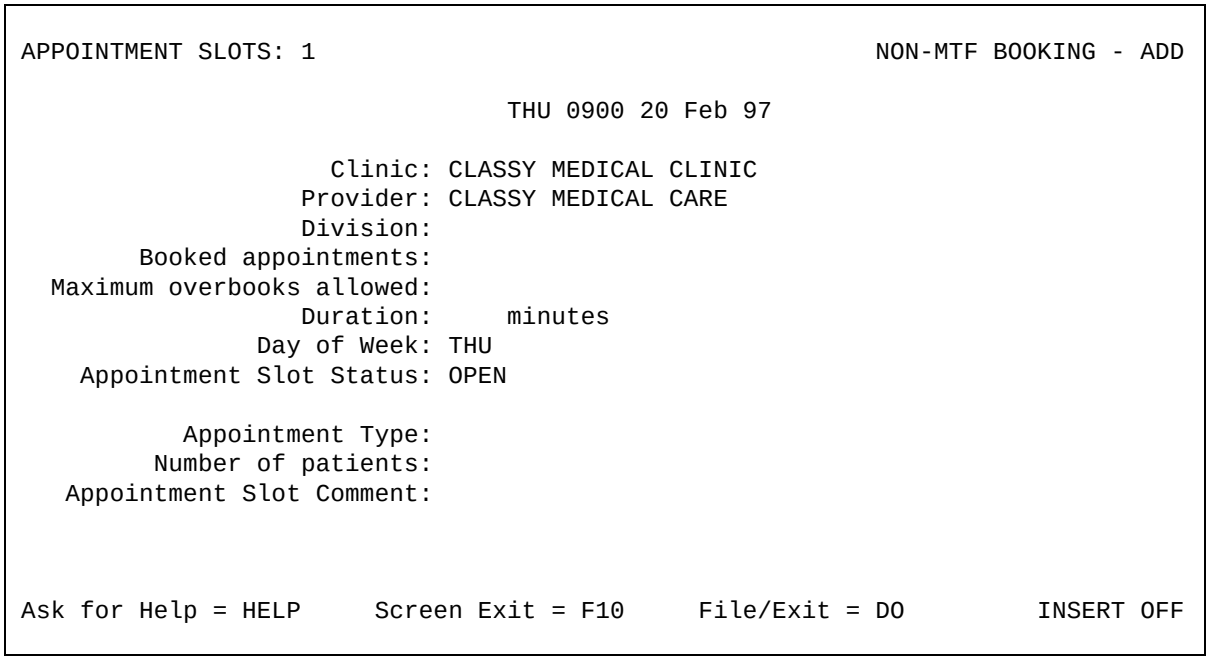

Figure 6-16. Non-MTF Booking - Add Screen

1. Clinic

   The full name and location of the clinic. Display only, cannot be edited.

2. Provider

   Either the full name of the “referred to” provider or the name of the group provider. Display only, cannot be edited.

3. Division

4. Booked appointments

5. Maximum overbooks allowed

6. Duration

   The length of time required for the appointment in minutes.

7. Day of Week

   The day of the week of the appointment. Display only, cannot be edited.

8. Appointment Slot Status

May be open or closed. Display only, cannot be edited.

9. Appointment Type

   Required field must be completed or verified. The appointment type entered must be active for the specified clinic/provider. The appointment type must be an entry in the appointment type table. New appointment types can be added using the Appointment Type Enter/Edit (APRO) option on the Scheduling Supervisor Profiles Menu. Enter a double question mark (??), then press <Return> to display a list of active appointment types.

10. Number of patients

    Required field, must be completed or verified. The system enters this number for you according to how the selected appointment was set up in the Appointment file. The cursor bypasses this field. Some appointment types are set up to allow more than one patient to be scheduled into a slot. For example, a diabetes education class could be set up as an appointment type with the number of patients set at the desired class size.

11. Appointment Slot Comment

    Optional field. Can be used to enter an additional 3 to 50 characters of information about the appointment slot.

File the data

An action bar displays that allows you to file the data and exit the option, abort the process without filing, or edit. If you choose to edit the data, the cursor returns to the Appointment Type field where and you can edit the appointment type or appointment slot comments. If you choose to abort, you return to the Add an Appointment Slot screen where you can reenter an appointment date and time.

When you accept the default to file/exit, you return to the Add an Appointment Slot screen, which now shows the appointment you just entered. Refer to Figure 6-17. Add an Appointment Slot with One Slot Already Created, page 6-32. You can enter another appointment slot or press <Return> to continue.

```
                          ADD AN APPOINTMENT SLOT
Patient: BLITON,STEVEN                                    FMP/SSN: 06/278-55-5025
Patient Type: MCP/CHAMPUS ELIGIBLE                       Appt Type:FOL
Clinic: CLASSY MEDICAL CLINIC/MCPD                        Specialty: FAMILY CARE
Clinic Phone: 619-535-7116
Provider: CLASSY MEDICAL CARE                             Duration:
Location: 92128                                           Days of Week: M TU W TH
F
Dates: 17 Feb 1997 to 31 Mar 1997                         Time Range: 0900 to
1400
_____________________________________________________________________________
__
 * THU 0900 20 Feb 97 FU     1/0   10 MIN  OPEN
                   <---Enter appointment date@time




_____________________________________________________________________________
__
Enter appointment date@time to be added to the provider's schedule or
Press <RETURN> to continue.
```

Figure 6-17. Add an Appointment Slot with One Slot Already Created

Press <Return> to continue.

The system displays the File Appointment screen. Refer to Figure 6-11. File Appointment Screen, page 6-21, for an example.

Book the appointment(s)

File the data

Print patient's appointment(s)/Wait List requests

Continue booking appointments or exit the option

6.1.2 Non-Enrolled Booking (NHCF)

Menu Path: PAS System Menu → M → NHCF

Alternate Menu Path: PAS System Menu → M → HMCP → NHCF

- **Security Keys**

  CPZ CCP*

  * Needed by all MCP users. No other security keys required to access this option.

- **Required Fields**

  Patient name
  Patient type
  Appointment type
  Specialty
  Location
  Provider

- **Application Description**

The Non-Enrolled Booking option allows you to book primary care and specialty appointments with one network or non-network provider at a time for patients who are not currently enrolled in MCP. This option also allows you to book appointments for patients who are conditionally enrolled or pending enrolled.

- **Business Rules**

– If the appointment is made as a result of a referral, use the Appointment Referral Booking (AHCF) option.

– MTF appointments may be booked. Non-MTF appointments are only recorded in the data base for reporting. Non-MTF appointments are not actually booked into the provider's schedule.

– Eligibility checks are performed on all patients.

– Ineligible patients may only book with an override.

Refer to Business Rules, page 6-5, for other rules.

- **Data Entry Process**

Book a non-enrolled patient with an MTF Provider

Scenario:

You need to book an appointment in your MTF for a Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) patient not enrolled in TRICARE Prime.

Access the NMCP or NHCF option

Select search criteria to change

Select the patient

Review current DEERS eligibility

Review patient demographics

Enter provider search criteria

Search for a provider

Select a provider

Select the appointment(s) or add an appointment slot

Book the appointment(s)

Print patient appointments/Wait List requests

Exit the option

Access the NMCP or NHCF option

When you select the NHCF option on the Managed Care Program Menu or the NHCF option on the Health Care Finder Menu, the Non-Enrolled Booking Search Criteria screen displays. Refer to Figure 6-18. Non-Enrolled Booking Search Criteria Screen, page 6-35.

```
                      NON-ENROLLED BOOKING SEARCH CRITERIA
Patient:                                                FMP/SSN:
Patient Type:                                           Appt Type:
Clinic:                                                 Specialty:
Clinic Phone:
Provider:                                                Duration:
Location:                                                Days of Week:
Dates: 21 Jun 2001 to 02 Aug 2001                        Time Range: 0001 to
2400
_____________________________________________________________________________
__



________Patient, Patient Type, Specialty, Location, Provider are
required________
Select (C)hange Search Criteria, or (Q)uit: C//
```

Figure 6-18. Non-Enrolled Booking Search Criteria Screen

The Non-Enrolled Booking Search Criteria screen has three windows: The top Display Window contains the patient demographic and provider fields. These fields are blank at this point, but fill in as the search criteria are defined. The Dates and Time Range fields are defaulted by the system, but can be edited.

The middle Select Window, is also blank at this point, except for data selection instructions.

> **Note:** Patient, Patient Type, Specialty, Location, and Provider fields are required search criteria fields.

The bottom Interact Window contains the action bar. Only two actions are available: (C)hange Search Criteria, or (Q)uit.

Select (C)hange Search Criteria, or (Q)uit: C//

Accept the default (C)hange Search Criteria action.

Select search criteria to change

The middle Select Window displays selectable search criteria on the Non-Enrolled Booking Search Criteria screen. Refer to Figure 6-19. Non-Enrolled Booking Search Criteria Screen, page 6-36.

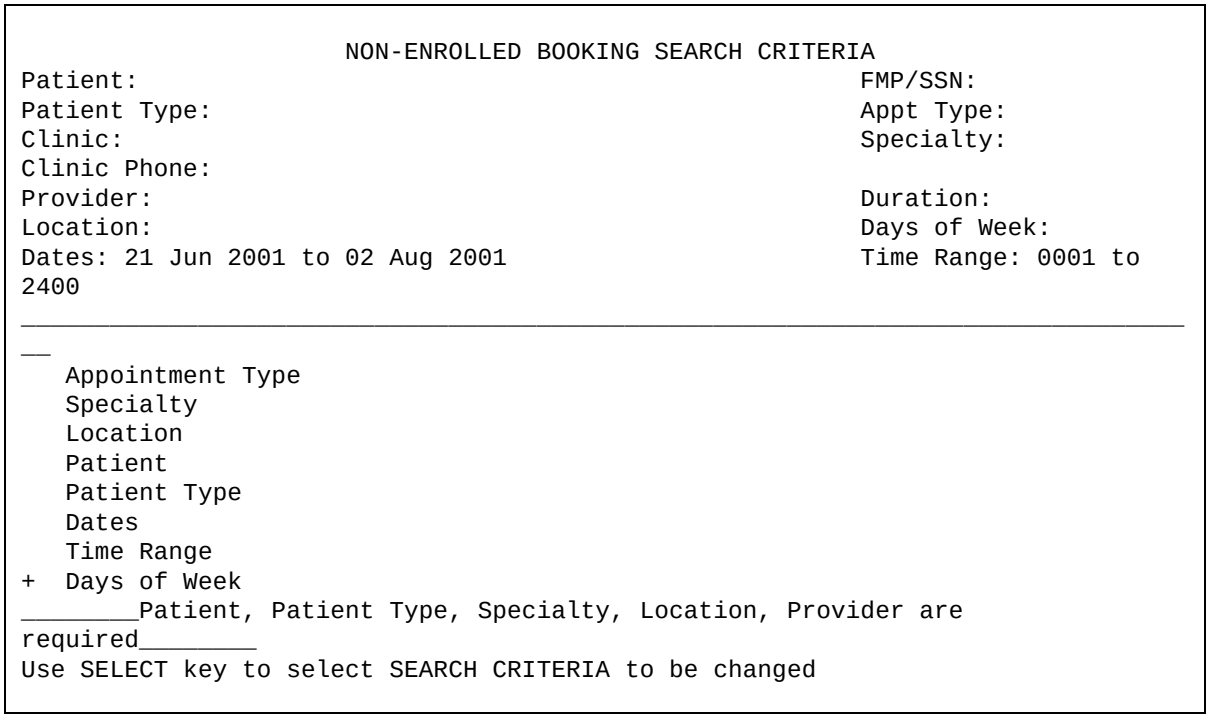

Figure 6-19. Non-Enrolled Booking Search Criteria Screen

1. Use the down-arrow key to position the cursor next to each of the desired search criteria, then press <Select>.

> **Note:** Patient, Patient Type, Specialty, Location, and Provider fields are required search criteria fields.

2. When you have selected criteria to change, press <Return>. You are prompted to enter the patient name only if you choose patient as one of the initial search criteria. You are prompted again to change the criteria if any of the required criteria are not initially chosen.

Select the patient

Review current DEERS eligibility

Review patient demographics

Enter C to select the (C)ontinue action.

Enter provider search criteria

The Non-Enrolled Booking Search Criteria screen displays. Refer to Figure 6-20. Non-Enrolled Booking Search Criteria Screen 3, page 6-37.

```
                        NON-ENROLLED BOOKING SEARCH CRITERIA
Patient: PHOTON,ZACHARY N                                  FMP/SSN:20/353-30-4614
Patient Type:                                              Appt Type:
Clinic:                                                    Specialty:
Clinic Phone:
Provider:                                                  Duration:
Location:                                                  Days of Week:
Dates: 21 Jun 2001 to 02 Aug 2001                          Time Range: 0001 to
2400
_____________________________________________________________________________
__




_____________________________________________________________________________
__
Select PATIENT TYPE:
```

Figure 6-20. Non-Enrolled Booking Search Criteria Screen 3

1. Patient Type

   The correct patient type is very important because the system matches it with compatible provider agreement types when locating a health care provider (HCP). Enter a double question mark (??) to display the following list of patient types:

AD	ACTIVE DUTY
CHA	CHAMPUS
MED	MEDICARE
OTH	OTHER

SCD SUPPLEMENTAL CARE DIAGNOSIS

2. Specialty Type

   Enter the type of medical specialty your patient requires. Enter a double question mark (??) to display a list of choices.

3. Location

   Enter the ZIP code where your patient is to receive medical care.

4. Dates

   Enter start and stop dates. You can use these criteria to limit your search to a specific range of days. For example, if the patient needs an appointment approximately 30 days from today, enter T+30 as the start date and T+37 as the stop date. The system only searches for open appointments during a seven-day period beginning 30 days from today.

   The default start date is always today's date, and the default stop date is always six weeks from today's date. You can change the start date to any date in the future; you can change the stop date to any date in the future as long as the stop date you enter is later than the start date.

5. Time Range

   Enter inclusive earliest and inclusive latest time. You can use these two criteria to limit your search to a specific time of day. For example, your patient may ask for an afternoon appointment. For this patient, you might enter 1300 as the inclusive earliest time and 1700 as the inclusive latest time. The system would only search for open appointments between the hours of 1:00 and 5:00 pm.

   The default inclusive earliest time is 0001. The default inclusive latest time is 2400.

6. Days of Week

   Refer to Figure 6-8. Prompt to Select Acceptable Days of the Week for an Appointment, page 6-18.

7. Duration

If you selected duration as a search criteria, enter the number of minutes required for the appointment as a one- to three-digit number.

8. Appt Type

   Enter a double question mark (??) at this prompt to display appointment types. You can only select one appointment type from appointment types that have been previously entered in the facility profile.

Search for a provider

When you have entered all selected search criteria, the bottom Interact Window displays a new action bar on the Non-Enrolled Booking Search Criteria screen. The middle Select Window displays the patient home phone number. Refer to Figure 6-21. Non-Enrolled Booking Search Criteria Screen with Provider Search Action Bar, page 6-39.

```
                      NON-ENROLLED BOOKING SEARCH CRITERIA
Patient: PHOTON,ZACHARY N                        FMP/SSN: 20/353-30-4614
Patient Type: CHAMPUS                            Appt Type:
Clinic:                                          Specialty: DERMATOLOGY
Clinic Phone:
Provider:                                         Duration:
Location: DISTRICT OF COLUMBIA                    Days of Week:
Dates: 21 Jun 2001 to 02 Aug 2001                 Time Range: 0001 to 2400
_____________________________________________________________________________
__
  Patient Home Phone: 410-555-0602              Patient Duty Phone:




_________________________Provider is
required_____________________________
Select (C)hange Search Criteria, (P)rovider Search, or (Q)uit: P//
```

Figure 6-21. Non-Enrolled Booking Search Criteria Screen with Provider Search Action Bar

Accept the default (P)rovider Search action.

A new action bar displays. Refer to Figure 6-22. Provider Name, MTF, External, Non-Network Provider Search Action Bar, page 6-40.

```
Search for (P)rovider Name, (M)TF, (E)xternal, N(o)n-Network,
```

```
                                or (Q)uit Provider Search:
```

Figure 6-22. Provider Name, MTF, External, Non-Network Provider Search Action Bar

1. Enter the type of provider search.

   The action bar allows you to search for the following:

   – A specific provider by name

   – An MTF provider

     When you select MTF, the system searches for providers with an agreement type that meets the search requirements specified in the referral. The type may be CON, MTF, PIC, or SUP; the place of care must have a location type of C (clinic) or S (same day surgery).

   – An external (civilian) provider

     When you select External, the system searches for providers with an agreement type that meets the search requirements specified in the referral. The type may be PEX, NET, CON, or SUP; the place of care must have a location type of O.

   – A non-network provider.

2. Enter search values

   If you choose the (P)rovider Name action, you are prompted to select a provider name.

   If you choose the (M)TF, (E)xternal, N(o)n-Network actions, you are prompted to select an appointment type.

   Enter a double question mark (??) to view available appointment types. You can select only appointment types previously entered in the facility profile.

3. Quit.

Select a provider

If you do not enter an appointment type at this prompt, the middle Select Window displays a list of providers that match your search criteria with all their open appointments.

If you choose the (Q)uit Provider Search action, you return to the action bar. When you have entered all search criteria, a new action bar displays on the Non-Enrolled Booking Search Criteria screen. Refer to Figure 6-21. Non-Enrolled Booking Search Criteria Screen with Provider Search Action Bar, page 6-39.

If you enter a specific appointment type, the middle Select Window displays a list of providers that match your search criteria with only the type of open appointments you entered. Refer to Figure 6-23. Non-Enrolled Booking Search Criteria Screen with Available MTF Appointments, page 6-41.

```
                      NON-ENROLLED BOOKING SEARCH CRITERIA
Patient: BLITON,JACK                              FMP/SSN: 20/353-30-4614
Patient Type: USA ACTIVE DUTY ENLISTED            Appt Type:NEW
Clinic:                                           Specialty: CARDIOLOGY
Clinic Phone:
Provider:                                         Duration:30
Location: SAN DIEGO                               Days of Week:M TU W TH F
Dates: 21 Jun 2001 to 02 Aug 2001                 Time Range: 0800 to 1400

    Provider          CS Cat   Agr Place of Care   Zip     1st Available Appt
_____________________________________________________________________________
__
+   PARKWAY,ZELDA        MD    MTF CCG/OP MTF      20307   22 Jun 2001@0800
    PANTOUM,CAROL     E  MD    MTF CCG/OP MTF      20307   23 Jun 2001@0800
    PARAMOUNT,DOUGL   B  MD    MTF CCG/OP MTF      20307   23 Jun 2001@0800
    PARANG,ELISA      B  MD    MTF CCG/OP MTF      20307   23 Jun 2001@0800
    PARAPH,FRANK      B  MD    MTF CCG/OP MTF      20307   27 Jun 2001@0800
    PARCAE,GEORGIA    B  MD    MTF CCG/OP MTF      20307   27 Jun 2001@0800
    PARCENER,HENRY    B  MD    MTF CCG/OP MTF      20307   27 Jun 2001@0800
    PARGET,IOLA M     B  MD    MTF CCG/OP MTF      20307   28 Jun 2001@0800
    PARITY,JOSEPH     B  MD    MTF CCG/OP MTF      20307   23 Jun 2001@0800
+   PANACHE,ZELDA M   B  MD    MTF CCG/OP MTF      20307   28 Jun 2001@0800
_____________________________________________________________________________
__
Use the SELECT key to Select the Provider to whom to refer the patient
Press F9 to view Schedule, Discount Summaries, Place of Care, or Watch Codes
```

Figure 6-23. Non-Enrolled Booking Search Criteria Screen with Available MTF Appointments

1. Use the down-arrow key to scroll through the list to find the first available appointment acceptable to the patient.

2. When the cursor is positioned, press <Select>.

   The Non-Enrolled MTF or Non-Enrolled Non-MTF Booking Search Criteria screen displays. Refer to Figure 6-24. Non-Enrolled MTF Booking Search Criteria Screen, page 6-42. This screen allows you to perform other actions or to change your previous selection.

Note: The Non-Enrolled MTF Booking Search Criteria screen and the Non-Enrolled Non-MTF Booking Search Criteria screen are identical except for the screen title.

```
                    NON-ENROLLED MTF BOOKING SEARCH CRITERIA
Patient: BLITON,JACK                                  FMP/SSN: 20/876-55-0505
Patient Type: USA ACTIVE DUTY ENLISTED                Appt Type: NEW
Clinic: CARDIOLOGY CARE CLINIC                        Specialty: CARDIOLOGY
Clinic Phone: 202 456-9877
Provider: PARKWAY,ZELDA M                              Duration: 30
Location: SAN DIEGO                                 Days of Week: M TU W TH F
Dates: 21 Jun 2001 to 02 Aug 2001                     Time Range: 0800 to 1400
_____________________________________________________________________________
__
  Patient Home Phone: 410-555-0602           Patient Duty Phone: 410-555-1234




__________Provider eligibility dates are from 21 Jun 2001 to 02 Aug
2001_________
Select (C)hange Search Criteria, (P)rovider Search, (B)rowse, (S)ingle Patient,
       Appt (R)efusal, (W)ait List Add, (T)el-Consult, or (Q)uit: S//
```

Figure 6-24. Non-Enrolled MTF Booking Search Criteria Screen

The Non-Enrolled MTF Booking Search Criteria action bar includes the following actions:

- **(C)hange Search Criteria -** Changes the search criteria for the appointment requested.
- **(P)rovider Search -** Searches for providers based on patient type, specialty type, and location. Allows you to select the type of provider to search for (i.e., MTF, civilian, or non-network).
- **(B)rowse -** Searches the schedule of the selected provider for bookable appointment slots on a specific day. This search locates not only open appointment slots, but also locates and displays booked, frozen, wait listed, and canceled appointment slots. Slots can be joined, split, and overbooked using the Browse action. You can also change the appointment type using the Browse action.

- **(S)ingle Patient -** Searches for one or more bookable appointments for a single patient that meet the specified search criteria. Only open appointment slots are searched for and displayed.
- **Appt (R)efusal -** Enters a patient's appointment refusal. This may be done with or without booking an appointment or making a formal referral.
- **(W)ait List Add -** Places this patient on the Wait List for the specified MTF clinic.

> **Note:** This action is available only if the specified clinic maintains an active Wait List.

- **(T)el-Consult -** Documents a telephone call from a patient who calls a HCF to leave a message for a provider.
- **(Q)uit -** Quits the MTF (or Non-MTF) Booking Search Criteria screen and returns to the Managed Care Program Menu.

4. Accept the (S)ingle Patient action on the MTF Booking Search Criteria action bar.

> **Note:** When you accept the default (S)ingle Patient action on the Non-Enrolled Non-MTF Booking Search Criteria screen, the Add an Appointment Slot screen displays. Refer to Figure 6-14. Add an Appointment Slot Screen, page 6-28, for an example. An appointment slot is added in Non-Enrolled Booking in the same manner as in PCM Booking. Refer to Add an appointment slot, page 6-29.

Select the appointment(s) or add an appointment slot

The middle Select Window displays list of the selected provider's open appointments that meet your selection criteria. Refer to Figure 6-25. Non-Enrolled MTF Single Patient Booking Screen, page 6-44.

```
                    NON-ENROLLED MTF SINGLE PATIENT BOOKING
Patient: BLITON,JACK                                  FMP/SSN: 20/876-55-0505
Patient Type: USA ACTIVE DUTY ENLISTED                Appt Type: NEW
Clinic: CARDIOLOGY CARE CLINIC                        Specialty: CARDIOLOGY
Clinic Phone: 202 456-9877
Provider: PARKWAY,ZELDA M                             Duration: 30
Location: SAN DIEGO                                   Days of Week: M TU W TH F
Dates: 21 Jun 2001 to 02 Aug 2001                     Time Range: 0800 to 1400
_____________________________________________________________________________
__
   FRI 0800 22 Jun 01 NEW    1/0
   FRI 0830 22 Jun 01 NEW    1/0
```

```
   FRI 0900 22 Jun 01 NEW    1/0
   FRI 0930 22 Jun 01 NEW    1/0
   FRI 1000 22 Jun 01 NEW    1/0
   FRI 1030 22 Jun 01 NEW    1/0
   FRI 1100 22 Jun 01 NEW    1/0
+  FRI 1130 22 Jun 01 NEW    1/0
_____________________________________________________________________________
__
Use SELECT key to select appointment(s) to be booked
```

Figure 6-25. Non-Enrolled MTF Single Patient Booking Screen

Position the cursor beside the appointment(s) acceptable to your patient, press <Select>, then press <Return>.

Book the appointment(s)

The File Appointment screen displays. Refer to Figure 6-11. File Appointment Screen, page 6-21.

Print patient appointments/Wait List requests

Exit the option

6.1.3 Appointment Referral Booking (AHCF)

Menu Path: PAS System Menu → M → HMCP → AHCF

- **Security Keys**

  CPZ CCP
  CPZ OHI
  CPZ CASE
  CPZ NAS

- **Required Fields**

  Patient name
  Patient type
  Specialty
  Location

- **Application Description**

The Appointment Referral Booking option allows you to enter/edit an appointment referral for specialty care for an enrolled or non-enrolled patient and book one or more appointments for the patient with network or non-network providers. Patient preferences are considered when searching for appointments. Enrollees with an MCP status of Pending, Invalid, or Conditional must be booked in Non-Enrolled Booking.

Although the system allows appointments to be canceled only through the Cancellation by Patient (CMCP) option in MCP, the system allows referrals without appointments to be deleted in this option. Appointments canceled by the facility must be entered in PAS.

- **Business Rules**

– Eligibility checks are performed on all patients.

– Ineligible patients may only be booked with an override.

– If help is requested at the Referred By field on the Interview/Referral - Continued screen, and the patient is not enrolled in MCP, all network providers display alphabetically.

- **Data Entry Process**

Scenario

Your first scheduling task is to add an appointment referral for an enrolled patient to have a dermatologist remove some suspicious skin lesions. After you enter the patient's name and verify that the demographic information is correct, you add an appointment referral for this patient in the local area for a one-time, routine visit. You find a HCP, book the appointment, and print the Care Authorization Form (CAF).

6.1.3.1 Enter an Appointment Referral for an Enrolled Patient

Access the AHCF option

Select the patient

Review current DEERS eligibility

Review patient demographics

Enter appointment referral/patient preference data

File the data or edit or abort the referral

Access the AHCF option

Select the patient

1. Select (P)atient or (Q)uit: P//

   Accept the default (P)atient action on the Appointment Referral Booking screen.

   The *Select (P)atient or (Q)uit: P//* prompt is replaced with the *Select PATIENT NAME* prompt.

2. Select PATIENT NAME

   Enter the patient ID using your site's preferred method of patient lookup. If the patient is not registered in CHCS, the system asks if you are adding a new patient. If you answer "Y," the system prompts you to register the patient using Mini Registration. If you answer "N," you return to the *Select PATIENT NAME* prompt.

   If the patient is registered, the system displays the patient's FMP, the sponsor's SSN, the patient's DOB, sex, and rank if the patient is the sponsor and asks you to confirm the information is correct.

3. OK? Yes//

   Verify the sponsor name. If the sponsor name is correct, press <Return>.

Review current DEERS eligibility

Refer to Review Current DEERS Eligibility, page 6-9.

Note:

Enrollment in USTF Managed Care - Following the DEERS check, the system searches the stored DEERS eligibility information to determine if the patient is assigned an Alternate Care Value (ACV) code of "U" (Enrolled in USTF Managed Care).

The Uniformed Services Treatment Facility (USTF) Managed Care Program is a network of Department of Defense (DOD)-owned, civilian contractor-staffed medical facilities that provides DOD-funded medical care to eligible participating DOD beneficiaries (patients). The USTF Managed Care Program may be offered, where available, to eligible beneficiaries as an alternative to other DOD managed care programs and direct care from the MTF (active-duty patients are ineligible). USTF beneficiaries should only receive care at an MTF by prior agreement or emergency.

If the specified patient is not assigned an ACV code of "U", the system allows you to continue the booking process without restriction. If the patient is assigned an ACV code of "U", the system displays the DEERS Eligibility Data screen with the following message:

> This patient is a Uniformed Services Treatment Facility (USTF) enrollee who elected, in writing, to receive all non-emergency care from a USTF. Your facility will not be reimbursed for care provided to this patient unless the USTF agrees to pay your facility prior to you rendering services to the patient.

You can choose either to continue the booking process for the selected patient without restriction, or to abort it for this patient.

If you choose to abort the current booking process for this patient, you can return to the change search criteria action to select another patient and/or change other search criteria, or quit the action.

Review patient demographics

Refer to Review patient demographics, page 6-10. Select the (C)ontinue action.

The Appointment Referral Booking screen displays. Refer to Figure 6-26. Appointment Referral Booking Screen, page 6-48. This screen displays combined demographic and enrollment data about the patient and allows you to view existing open referrals and select an action.

```
                          APPOINTMENT REFERRAL BOOKING
           Patient: PICARD,ZACHARY E                  FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER           Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                       DDS: 20
      Patient Type: ACTIVE DUTY                           Sex: MALE
        MCP Status: ENROLLED
               PCM: ESPOSITO,FRANK M                PCM Phone: 202 271-5850
Case Mgmt Provider:                                 Case Mgmt: NO

     Referral#  Date/Time         Provider            Specialty        Status
_____________________________________________________________________________
__




_____________________________No Appointment Referrals
found_____________________________
Select (P)atient, (A)dd, or (Q)uit: A//
```

Figure 6-26. Appointment Referral Booking Screen

The Appointment Referral Booking screen contains three windows.

The top Display Window lists the patient name, patient category, DOB/age, patient type, MCP status, assigned PCM, case management provider (if any), FMP and sponsor SSN, patient SSN, DEERS dependent suffix (DDS) if active-duty, sex, assigned PCM's phone number, and whether the patient is a case management patient. The Case Management Provider and Case Management fields are automatically filled in if a referral has been entered or selected to be modified and a case management provider with the same specialty as entered in the referral has been assigned to the patient.

> **Note:** The data shown in the top Display Window is from information in the CHCS data base, not from DEERS. Refer to Figure 6-26. Appointment Referral Booking Screen, page 6-48.

The middle Select Window lists all referrals already on file for the patient, including the referral number, date and time the referral was entered, the provider referred to, the provider's specialty, and the status of the referral. If no referrals are already on file, a message displays at the bottom of the middle Select Window stating, "*No referrals found*." Refer to Figure 6-26. Appointment Referral Booking Screen, page 6-48.

The bottom Interact Window contains the action bar with the following available actions:

- **(P)atient -** Selects a new patient and restart the appointment referral process.
- **(A)dd -** Displays the Interview/Referral screen and enter a new referral with the patient interview/ referral information.
- **(M)odify -** Modifies an existing referral. When you select Modify, the system allows you to select a referral from the list of existing referrals. Referrals with no appointments or providers attached display at the top of the list in referral number order, followed by referrals with appointments linked to them. After you select a referral, the system displays the Interview/Referral screens for the selected referral and allows you to advance through the fields and enter/edit data.

> **Note:** The Modify action only appears on the action bar if the patient has existing referrals.

- **(Q)uit -** Quits the appointment referral process and returns to the Health Care Finder Menu.

Enter appointment referral/patient preference data

When you choose the default (A)dd action from the Appointment Referral Booking action bar, the Interview/Referral screen displays. Refer to Figure 6-27. Interview/Referral Screen, page 6-50.

```
MCP REFERRAL: 200100058                                    INTERVIEW/REFERRAL

            Patient: PICARD,ZACHARY E                FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER          Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                      DDS: 20
                                                         Sex: MALE
            Street: 862 WEST WYLAND DR                  City: FAIRFAX
             State: VIRGINIA                         ZIP Code: 22030
           H Phone: 918-555-0287                      D Phone: 202-555-6802
           W Phone: 202-555-6802
               PCM: ESPOSITO,FRANK M               PCM Phone: 202 271-5850
Case Mgmt Provider:                                Case Mgmt:
================================================================================
==
      Referral Number: 200100058          Referral Date/Time: 21Jun01@1439
           MCP Status: ENROLLED                 Patient Type: ACTIVE DUTY
            Specialty:
             Location:
 Requested Start Time: 0001              Requested Stop Time: 2400
         Days of Week:                      Number of Visits:
 Treatment Start Date:                   Treatment Stop Date:
             Priority:                     Gender Preference:
             Language:                           Primary OHI:
```

Figure 6-27. Interview/Referral Screen

The Interview/Referral screen has a two-window format:

The Display Window displays the current demographic information for the patient, as well as PCM, and case management information.

The Interact Window contains those fields that must be completed when specifying referral information. The system automatically enters the Referral Number, Referral Date/Time, and the patient's MCP Status fields. These fields cannot be edited. The cursor is positioned at patient type.

1. Patient Type

   Defaults by the system from the patient's enrollment information in the Patient file. You can either accept the default or edit this field.

Patient types include the following:

	Enrolled
MCA	MCP/Active Duty (i.e., active-duty, enrolled)
MCP	MCP/CHAMPUS Eligible (i.e., not active-duty, CHAMPUS eligible, enrolled)
MCD	MCP/Non-CHAMPUS Eligible (i.e., not active-duty, not CHAMPUS eligible, enrolled)
	Non-Enrolled
AD	Active Duty (i.e., active duty, nonenrolled)
CHA	CHAMPUS (i.e., not active-duty, CHAMPUS-eligible, nonenrolled)
OTH	Other (i.e., direct care that is not CHAMPUS or MEDICARE, nonenrolled)
	Enrolled or Non-Enrolled
MED	MEDICARE (i.e., not active-duty, not CHAMPUS-eligible enrolled or nonenrolled)
SCD	Supplemental Care Diagnostics (i.e., a one-time offsite care authorization for a specific test or procedure (e.g., MRI), enrolled or non-enrolled). **Note:** This patient type is new with CHCS Version 4.5.

2. Specialty

   Your entry in this field restricts the referral into a primary clinical area. It identifies the MCP Specialty Type used by the system to search for providers and to group referrals for reporting purposes. It also links provider specialties to specific specialty types, allowing you to display a picklist with different specialties. For example, if you enter “occu,” a picklist displays of all specialty types beginning with those letters. Individual specialties may be grouped under a more general specialty in file and table build so that the search selects a broader range of appointments.

   If you are editing/modifying a previously entered referral, the Specialty field is only available for editing if no appointments have yet been linked to this referral.

3. Location

   You can enter either the ZIP code(s) for the area where the patient wants to receive medical care, or the geographical area (e.g., San Diego, Norfolk) already defined in the CHCS ZIP Code Combination file.

If a ZIP code is entered instead of a geographical area name, up to five different ZIP codes can be entered in this field at one time (with commas and no spaces).

You can also enter up to five "wild card" ZIP codes with at least the first three digits (e.g., 923) separated by commas. The system searches for all ZIP Codes that contain those first three digits.

Note: In CHCS Version 4.4, the specialty and location fields did not restrict the ability to book appointments for this referral. In CHCS Version 4.5 and later, these fields restrict the appointments as defined here.

4. Requested Start Time and Requested Stop Time

   The Requested Start and Stop Time fields allow you to enter the patient's preference for the appointment time range. The time must be stated military style. The default start time is 0001, and the default stop time is 2400.

5. Days of Week

   Enter the days of the week on which your patient can accept an appointment. After you enter the requested stop time, the system adds instructions for selecting days of the week on which your patient can accept an appointment.
   Refer to Figure 6-8. Prompt to Select Acceptable Days of the Week for an Appointment, page 6-18.

6. Number of Visits

   You must specify either the number of visits (a whole number between 0 and 99) or the treatment start and stop dates (date range). The system is very flexible at this point, and you can schedule the following:

   – An unlimited number of appointments within a specific date range by leaving the Number of Visits field blank and entering information into the Treatment Start and Stop Date fields.

   – An exact number of appointments for an unlimited date range by entering information in the Number of Visits field and leaving the Treatment Start and Stop Date fields blank. If no date range is entered, the system defaults the date range from T (today) to T + 60.

– An exact number of appointments for a specific date range by entering information in all three fields.

7. Treatment Start Date and Treatment Stop Date

   The Treatment Start Date and Treatment Stop Date fields allow you to enter the required date range in which to schedule the appointments linked to this referral. You can enter a specific date, or T to accept the system default date. If you enter T plus a number (e.g., T+15), the system defaults to the date plus the number of days specified.

8. Priority

   Priority codes are used to measure access to care. Allowable priority codes are:

E	Emergency
U	Urgent
R	Routine
T	Today
7	Within 72 hours
4	Within 48 hours
2	Within 24 hours

9. Gender Preference

   You can enter (M)ale or (F)emale, or leave it blank. If the field is left blank, the system lists both male and female providers. You advance to the Referred By field on the Interview/Referral - Continued screen (bypassing the Language and Primary OHI fields). Both fields contain default enrollment information (if available) and cannot be edited. Refer to Figure 6-28. First Completed Interview/Referral Screen, page 6-54.

```
MCP REFERRAL: 200100058                                    INTERVIEW/REFERRAL

            Patient: PICARD,ZACHARY E                    FMP/SSN: 20/379-43-
6114
  Patient Category: USA ACTIVE DUTY OFFICER              Pat SSN:    379-43-
6114
           DOB/Age: 19 Feb 1966/35Y                          DDS: 20
                                                             Sex: MALE
            Street: 862 WEST WYLAND DR                      City: FAIRFAX
             State: VIRGINIA                              ZIP Code: 22030
           H Phone: 918-555-0287                           D Phone: 202-555-6802
           W Phone: 202-555-6802
               PCM: ESPOSITO,FRANK M                   PCM Phone: 202 271-5850
Case Mgmt Provider:                                    Case Mgmt:

================================================================================
=
      Referral Number: 200100058              Referral Date/Time: 21Jun01@1439
           MCP Status: ENROLLED                     Patient Type: ACTIVE DUTY
            Specialty: DERMATOLOGY
             Location: 20307
 Requested Start Time: 0800                  Requested Stop Time: 1600
         Days of Week: M TU W TH F              Number of Visits: 1
 Treatment Start Date: 21 Jun 2001          Treatment Stop Date: 06 Jul 2001
             Priority: ROUTINE                Gender Preference:
             Language:                              Primary OHI:
```

Figure 6-28. First Completed Interview/Referral Screen

When you press <Return> at the Gender Preference field, the system replaces the Interview/Referral screen with the Interview/Referral -- Continued screen with the cursor positioned at the Referred By field.

Refer to Figure 6-29. Interview/Referral - Continued (Completed), page 6-55, for the Interview/Referral - Continued screen completed for a patient.

```
MCP REFERRAL: 200100057                          INTERVIEW/REFERRAL -- CONTINUED

            Patient: PICARD,ZACHARY E                    FMP/SSN: 20/379-43-6114
   Patient Category: USA ACTIVE DUTY OFFICER             Pat SSN:    379-43-6114
            DOB/Age: 19 Feb 1966/35Y                         DDS: 20
       Patient Type: ACTIVE DUTY                             Sex: MALE
         MCP Status: ENROLLED
                PCM: ESPOSITO,FRANK M                PCM Phone: 202 271-5850
 Case Mgmt Provider:                                 Case Mgmt:

================================================================================
 Referred By: ESPOSITO,FRANK M                              UPIN:
 Referral From: BGAZ                                  Related To:
 Reason for Referral:
  Suspicious skin lesions




Ask for Help = HELP     Screen Exit = F10     File/Exit = DO          INSERT OFF
```

Figure 6-29. Interview/Referral - Continued (Completed)

1. Referred By

   Enter the name of the provider who is referring this patient for specialized care. For enrolled patients, the name of the patient's assigned PCM is defaulted unless the patient's assigned PCM is a provider group. If a provider group serves as a PCM or the patient is not enrolled, the system leaves the field blank, and you must enter the name of a specific provider who referred the patient. If you need help at the "Referred By" field, you may enter a double question mark (??) or the first few characters of the provider's name.

   If you enter a double question mark (??), a message displays that the referring physician may not necessarily be the patient's PCM. You are then prompted to select (L) or (Q)uit.

   If you select (L)ist, a list of providers belonging to the provider group assigned as the patient's PCM displays.

   If you do not select a provider from this initial list and press <Return>, a prompt asks if you would like to display the entire list of MCP providers. If you select the default "Y," the entire list of network and non-network providers displays. If you enter "N," ,you return to the Referred By field.

If the patient is not enrolled in MCP, and you enter a double question mark (??) at the Referred By field, you are prompted to select (L)ist or (Q)uit. If you select (L)ist, the entire list of all network providers alphabetically displays.

2. UPIN

   Defaults the provider's six-character Unique Physician Identification Number (UPIN) information from the Provider file. If this information was not entered into the Provider file, the field remains blank. Since the UPIN cannot be edited here, the cursor bypasses this field.

3. Referral From

   Defaults to the MEPRS code for the clinic in which this patient's PCM is assigned. Since the MEPRS code cannot be edited here, the cursor bypasses this field. If the patient is not enrolled, this field is left blank.

4. Related To

   Enter the patient activity that caused the need for this referral. This field indicates when the cost of the care may be reimbursable from other patient benefit plans. This field should be completed if applicable.

   Allowable activity codes are as follows:

WC	Work Condition
MS	Military Service
AA	Auto Accident

   If none of these codes apply to the actual patient activity that resulted in the need for this referral, this field can be left blank.

5. Reason for Referral

   Word processing field. You can enter unlimited narrative text about the reason for this referral. You can also leave this field blank.

   When you press <Return> at the Reason for Referral field, the system displays the third Interview/Referral screen. Refer to Figure 6-30. Interview/Referral - Continued 2, page 6-57.

```
MCP REFERRAL: 200100057                          INTERVIEW/REFERRAL -- CONTINUED

            Patient: PICARD,ZACHARY E                    FMP/SSN:20/379-43-6114
   Patient Category: USA ACTIVE DUTY OFFICER             Pat SSN:   379-43-6114
            DOB/Age: 19 Feb 1966/35Y                         DDS:20
       Patient Type: ACTIVE DUTY                             Sex:MALE
         MCP Status: ENROLLED
                PCM: ESPOSITO,FRANK M                 PCM Phone: 202 271-5850
 Case Mgmt Provider:                                  Case Mgmt:

================================================================================
=
 Select Provisional Diagnosis:



 Select Provisional Diagnosis (Free Text):



 Select Referral Procedure:



Ask for Help = HELP     Screen Exit = F10     File/Exit = DO
```

Figure 6-30. Interview/Referral - Continued 2

1. Select Provisional Diagnosis

   Describes the PCM’s request for a diagnostic consultation for the indicated condition.

   You must press <Return> one time before you can enter the code or anatomical name.

   You can enter the projected ICD-9 diagnosis code and/or the description that applies to the patient's medical condition for this referral; e.g., 172.5 is the ICD-9 code for malignant melanoma of the skin of the trunk.

   Enter a double question mark (??) to display a valid list of ICD-9 codes or enter an anatomical name (e.g., brain or femur) for a picklist of ICD-9 codes.

   Once you have entered the code, a prompt asks if you are adding that code as a new provisional diagnosis for this referral. Press <Return> to accept the default of Yes. If you made an error, enter No and reenter the correct code.

When you have verified that the code is correct, the description of the newly entered ICD-9 code displays next to the code you entered (in this example, 172.5 MALIGNANT MELANOMA OF SKIN OF TRUNK). The cursor is positioned below the code you just entered.

2. Press <Return> one time, then enter additional ICD-9 codes in this field or press <Return> two times to go to the next field.

3. Provisional Diagnosis (Free Text).

   Enter one line of free text in this field or leave it blank.

4. Referral Procedure

   Enter CPT codes for a referral to identify specific treatment(s) for which a beneficiary is being referred. You may enter a 3 to 5-digit CPT code, an alpha string to display a picklist of possible matches, an alpha string of the CPT-4 description, or enter a double question mark (??) to display a valid list of referral procedures. Separate, multiple entries can be made in the field. You cannot, however, enter a range of values. For example, if 272 is entered at the Select Referral Procedure field, the system displays a picklist of all procedures beginning with 272. Refer to Figure 6-31. Interview/Referral - Continued 3, page 6-59. You must select one of the values displayed.

   Once you have entered the code, a prompt asks if you are adding that code as a new referral procedure. If you press <Return> to accept the default of Yes, the description of the referral procedure displays.

File the data or edit or abort the referral

If you abort the referral, you return to the initial Add/Modify Referral action bar at the beginning of this action and purge all entries or changes that have occurred since the last entry was filed.

```
MCP REFERRAL: 200100057                          INTERVIEW/REFERRAL -- CONTINUED

            Patient: PICARD,ZACHARY E                    FMP/SSN:20/379-43-6114
   Patient Category: USA ACTIVE DUTY OFFICER             Pat SSN:   379-43-6114
            DOB/Age: 19 Feb 1966/35Y                         DDS:20
       Patient Type: ACTIVE DUTY                             Sex:MALE
         MCP Status: ENROLLED
                PCM: ESPOSITO,FRANK M                 PCM Phone: 202 271-5850
 Case Mgmt Provider:                                  Case Mgmt:

 27200   27200     CLOSED TREATMENT OF COCCYGEAL FRACTURE
 27202   27202     OPEN TREATMENT OF COCCYGEAL FRACTURE
 27215   27215     OPEN TX ILIAC SPINE(S), TUBEROSITY AVULSION, ILIAC WING FXS
 27216   27216     SKEL. FIXATION POSTERIOR PELVIC RING FX AND/OR DISLOCATION
 27217   27217     OPEN TX ANTERIOR RING FRACTURE AND/OR DISLOC W/INT.
FIXATION
 27218   27218     OPEN TX POSTERIOR RING FX AND/OR DISLOC W/INTERNAL FIXATION
 27220   27220     CLOSED TX ACETABULUM FRACTURE(S) WITHOUT MANIPULATION
+27222   27222     CLOSED TX ACETABULUM FX OR FXS W/MANIP. W/OR W/O SKEL.
TRAC.
  Make choice = SELECT                      Exit = F10
  272
```

Figure 6-31. Interview/Referral - Continued 3

6.1.3.2 Find a Provider

After you file the data and enter a referral, the Add Appointment Referral screen displays. Note that the newly entered referral displays. Refer to Figure 6-32. Add Appointment Referral Screen, page 6-60.

```
                           ADD APPOINTMENT REFERRAL
          Patient: PICARD,ZACHARY E               FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER       Pat SSN:    379-43-6114
          DOB/Age: 19 Feb 1966/35Y                    DDS: 20
     Patient Type: ACTIVE DUTY                        Sex: MALE
       MCP Status: ENROLLED
              PCM: ESPOSITO,FRANK M             PCM Phone: 202 271-5850
Case Mgmt Provider:                             Case Mgmt: NO

     Referral#  Date/Time         Provider            Specialty        Status
_____________________________________________________________________________
__
     200100057                                       DERMATOLOGY




_____________________________________________________________________________
__
```

```
Select (I)nterview/Referral, (P)rovider, (O)utputs, (D)elete,
       or (Q)uit ADD APPOINTMENT REFERRAL: P//
```

Figure 6-32. Add Appointment Referral Screen

The Add Appointment Referral screen contains three windows:

The top Display Window displays the current demographics for the selected patient. The Patient Name and FMP/SSN fields are highlighted. The data displayed is from CHCS.

The middle Select Window displays all appointment referrals ever generated for this patient. Since this newly created referral has no appointments linked to it yet, only the Referral Number and the Specialty Type fields display, without any booking information. If an appointment has already been booked, you cannot change the location and specialty. If an appointment has not been booked, you may select and edit the referral.

The bottom Interact Window displays the action bar with the following actions:

- **(I)nterview/Referral -** Returns to the Interview/Referral screen where you can modify the newly created referral.
- **(P)rovider -** Activates the referred to provider search.
- **(E)xception -** Searches for an exception provider assigned to the patient (only displayed on the action bar if the specified patient for the referral is a case management patient).
- **(O)utputs -** Generates a patient enrollment form, a patient membership ID card, a CAF, a patient mailing label, or a provider mailing label (if you have generated a CAF) for the selected appointment referral. After you complete this action, you return to the Appointment Referral action bar.
- **(D)elete -** Deletes the appointment referral. This action is only available for referrals that have no appointments linked to them and have never had appointments linked to them.
- **(N)AS -** Generates an NAS for the patient (only displayed on the action bar if the specified patient is CHAMPUS eligible). After you complete this action, you return to the Appointment Referral action bar.
- **(Q)uit ADD APPOINTMENT REFERRAL -** Quits the appointment referral process and returns to the Appointment Referral Booking screen to select another appointment referral to process.

Note: If you are editing/modifying a previously entered referral, the Modify Appointment Referral screen displays instead of the Add Appointment Referral screen. The Modify Appointment Referral action bar has the same actions as the Add Appointment Referral action bar, plus the following:

(B)ook - Proceeds to either the MTF booking action or the Non-MTF booking action, depending upon whether the patient's selected provider is an MTF provider or a non-MTF provider.

At the Add Appointment Referral action bar, press <Return> to accept the default (P)rovider action. The Provider Search screen displays. Refer to Figure 6-33. Provider Search Screen, page 6-61.

```
                                  PROVIDER SEARCH
           Patient: PICARD,ZACHARY E                    FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER             Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                         DDS: 20
      Patient Type: ACTIVE DUTY                             Sex: MALE
        MCP Status: ENROLLED
               PCM: ESPOSITO,FRANK M                 PCM Phone: 202 271-5850
Case Mgmt Provider:                                  Case Mgmt: NO
          Specialty: DERMATOLOGY                     Appt Type:
           Location: 20307
         Start Date: 21 Jun 2001                         Stop Date: 06 Jul 2001
       Days of Week: M TU W TH F               Number of Visits: 1
           Priority: ROUTINE                  Gender Preference:
           Language:                                Primary OHI: NOT ASSIGNED
_____________________________________________________________________________
__




_____________________________________________________________________________
__
Search for (A)ppt Refusal, (P)rovider Name, (M)TF, (E)xternal, N(o)n-Network,
            or (Q)uit Provider Search:
```

Figure 6-33. Provider Search Screen

The Provider Search screen contains three windows:

The top Display Window displays patient demographics, patient preferences, the patient's patient type, MCP status, assigned PCM, PCM phone number, specialty type, location, date to begin appointment search and date to end search. This window also displays the days of the week the patient can be available for the appointment, how many appointments are

required, priority assigned to the referral, whether the patient prefers a specific gender provider, and whether the patient requires/requests a provider who speaks a language other than English. In addition, the patient's primary OHI also displays. All data is displayed from data on file in the CHCS system.

The middle Select Window is blank.

The bottom Interact Window displays the Provider Search Action Bar with the following actions:

- **(A)ppt Refusal -** Documents a patient's refusal to schedule an appointment when appointments are available. Refer to Section 6.1.3.4 Enter Appointment Refusals (EHCF), page 6-106, for a complete description of the appointment refusal function.
- **(P)rovider Name =** MTF Provider Search - Searches for a specific provider by name. Refer to, page 6-64.
- **(M)TF** = MTF Provider Search - Searches for an MTF provider across the network of all MTF providers on the CHCS system. Refer to Book an appointment with an MTF provider, page 6-76.
- **(E)xternal -** Searches for a network provider outside the MTF. Refer to Appointment Referral Booking (AHCF) option on the Health Care Finder Menu.
- **N(o)n-Network -** Searches for a non-network provider. Non-Network providers are those providers with an agreement type of NON, who offer no discount (zero percent discount). Refer to Book an appointment with a non-network provider, page 6-100.
- **(Q)uit -** Quits the Provider Search action bar and returns to the Add Appointment Referral action bar.

- **Data Entry Process**

Book an appointment with a specific provider by name

Many times the patient's PCM may wish to refer the patient to a particular specialty care provider for follow-up care. For example, a patient may have had a previously bad skin condition which was treated by a Dermatologist, improved, but now has flared up again. In this case, once a referral has been entered for the patient, the HCF selects the Provider Name Search from the action bar. If the specified patient has a case management provider (that is, an exception provider assigned for the specialty type entered in the referral) the name of the case management provider automatically defaults at the *Select Provider* prompt. The HCF can accept the default or enter the name of a different provider. However, the provider

whose name is entered must have an agreement type that will see the patient's specified patient type.

Note: The provider name entered for a search must have an agreement type that can accommodate the patient's specified patient type. Otherwise, the system reports that no provider was found.

Additionally, if the specified patient has a case management provider (that is, an exception provider assigned for the specialty type entered in the referral), the case management provider name automatically defaults at the *Select Provider* prompt. You can accept the default or enter a different provider.

Access the AHCF option

Select the patient

Review current DEERS eligibility

Review patient demographics

Enter appointment referral/patient preference data

Select a specific MTF provider by name

View provider detail

Initiate the booking process

Book the appointment(s)

Print patient's appointments/Wait List requests

Print appointment referral products

Access the AHCF option

Select the patient

Review current DEERS eligibility

Review patient demographics

Enter appointment referral/patient preference data

The first five steps listed in the box above are the same whether your patient needs an MTF provider or a civilian provider. Assume you've already completed those steps and you are now at the Add Appointment Referral screen. Refer to Figure 6-34. Provider Search Screen, page 6-65.

When you select the (P)rovider Name action on the Provider Search screen, you are prompted to enter the name of the desired provider. When the selected provider is found, the system displays identifying data and prompts you for verification that the correct provider has been located. After the provider has been identified, the system prompts for the appointment type to use for the appointment search. If you bypass the appointment type identification, the system searches for all available appointments for the specified provider. The system then displays a list of the places of care for the specified provider, meeting the search criteria.

Select a specific MTF provider by name

```
                                  PROVIDER SEARCH
           Patient: PICARD,ZACHARY E                    FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER             Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                         DDS: 20
      Patient Type: ACTIVE DUTY                             Sex: MALE
        MCP Status: ENROLLED
               PCM: ESPOSITO,FRANK M                 PCM Phone: 202 271-5850
Case Mgmt Provider:                                  Case Mgmt: NO
          Specialty: DERMATOLOGY                     Appt Type:
           Location: 20307
         Start Date: 21 Jun 2001                     Stop Date: 06 Jul 2001
       Days of Week: M TU W TH F                Number of Visits: 1
           Priority: ROUTINE                   Gender Preference:
           Language:                                 Primary OHI: NOT ASSIGNED
_____________________________________________________________________________
__



_____________________________________________________________________________
__
Search for (A)ppt Refusal, (P)rovider Name, (M)TF, (E)xternal, N(o)n-Network,
            or (Q)uit Provider Search:
```

Figure 6-34. Provider Search Screen

1. Search for (A)ppt Refusal, (P)rovider Name, (M)TF, (E)xternal, N(o)n-Network, or (Q)uit Provider Search

   Enter “P” for Provider Name. The system replaces the action bar with a prompt to select provider name.

2. Select PROVIDER

   Enter the provider name.

3. OK? YES//

   Verify the provider name. The system prompts you to select appointment type.

4. Select APPT TYPE

   Press <Return> or enter the desired appointment type.

This requested appointment type must match the appointment types that are defined in the Master Appointment Type file and in the individual clinic/place of care and provider profiles (i.e., New, Consultation, or Followup). If you press <Return> the

system searches for all appointment types for the MTF providers with the specialty type and location for which you are searching.

The Provider Search screen displays with the selected provider's name and other information in the Select Window. Refer to Figure 6-35. Provider Search Screen, page 6-66.

```
                                  PROVIDER SEARCH
           Patient: PICARD,ZACHARY E                    FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER             Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                         DDS: 20
      Patient Type: ACTIVE DUTY                             Sex: MALE
        MCP Status: ENROLLED
               PCM: ESPOSITO,FRANK M                 PCM Phone: 202 271-5850
Case Mgmt Provider:                                  Case Mgmt: NO
          Specialty: DERMATOLOGY                     Appt Type:
           Location: 20307
         Start Date: 21 Jun 2001                     Stop Date: 06 Jul 2001
       Days of Week: M TU W TH F               Number of Visits: 1
           Priority: ROUTINE                  Gender Preference:
           Language:                                Primary OHI: NOT ASSIGNED

    Provider       CS Cat Agr Place of Care  Zip   1st Available Appt
_____________________________________________________________________________
__
  PANGLOSS,ANN M   B  MD  MTF DERM CARE MTF  20307 22 Jun 2001@1300



_____________________________________________________________________________
__
Use the SELECT key to Select the Provider to whom to refer the patient
Press F9 to view Schedule, Discount Summaries, Place of Care, or Watch Codes
```

Figure 6-35. Provider Search Screen

The Display Window still displays the same patient demographic and PCM information from the data in the CHCS system. The Select Window displays significant provider information:

– **Provider -** A tilde (~) located next to a provider name indicates that this provider speaks the preferred language of the patient. MTF Providers are listed on the screen in ZIP Code order and within each ZIP Code by first available appointment.

– **CS** = Certification Specialty - This is the level of board certification that this provider holds for this specialty and is often of interest to the patient. Levels (with code) are:

- Not certified (blank, no code)
- Board certified (BO)
- National certification (NA).

– **CAT** = Provider's Professional Category Code - The system contains more than 40 professional categories. Some of the more commonly used categories (with code) are:

- Surgeon (SUR)
- Medical Doctor (MD)
- Nurse Practitioner (NPC)
- Physician Assistant (PA)
- Occupational Therapist (OTH).

– **AGR** = Group/Military Provider Agreement Type - This agreement indicates the type of patients that providers will accept.

– **Place of Care** - The name of the clinic where the patient receives care.

– **ZIP** = ZIP Code of the Place of Care - Coincides with the search criteria entered previously.

– **1st Available Appointment** - Shows the first available appointment for each of the providers, based on the type of appointment selected.

– The plus (+) sign at the left of the bottom provider name indicates that the list of providers is longer than the display space. Use the down-arrow key to scroll through the list entire list.

The Interact Window displays the message to either select the provider or press <F9> to view the daily Schedules, Discount Summaries (percent of discount off the CHAMPUS maximum allowable charge - exception and only service available providers could have zero as their discount), Place of Care information such as directions, hours of service, or comments, or Watch Codes (inactivated indefinitely) for a particular provider.

1. Press <F9> (to access the Provider Discount Summary action bar).

   The Provider Discount Summary action bar actions include the following:

- **(O)verall Summary -** Displays the Individual Provider Discount Summary screen, which shows the overall discount rate for the selected provider.
- **(S)pecialty Exceptions -** Displays the Individual Provider Specialty Exceptions screen, which shows pricing exceptions for selected specialty care for this provider.
- **(C)PT Exceptions -** Displays the Individual Provider Procedure Exceptions screen, which shows pricing exceptions for specific medical procedures (CPT-4) performed by this provider.
- **(P)lace of Care -** Displays the Provider Group Places of Care screen, which shows directions to, comments about, and hours of services for this providers place of care.
- **(Q)uit -** Quits the <F9> expansion window and returns to the Provider Search screen where you can continue your provider selection.

2. Press <Return> to accept the default to view the Overall Summary for this provider.

View provider detail

The MCP Individual Provider Discount Summary screen displays.
Refer to Figure 6-36. MCP Individual Provider Discount Summary for an MTF Provider, page 6-69.

This screen displays the providers MCP Provider Group name, Agreement Type, the agreement's effective start and stop dates, overall discount rate (100% for an MTF provider), and whether the provider is designated as a PCM.

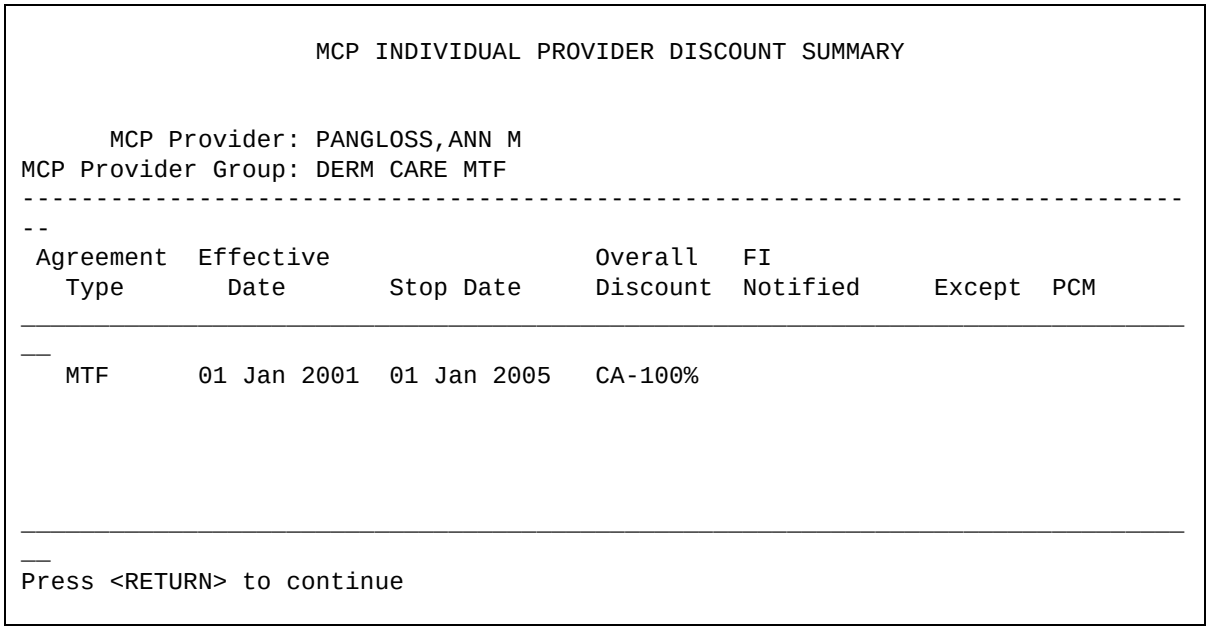

Figure 6-36. MCP Individual Provider Discount Summary for an MTF Provider

1. Press <Return> to continue.

   You return to the action bar.

2. Press <Return> to accept the (Q)uit action.

   The system positions the cursor beside the provider's name.

3. Press <Select>.

   The Add Appointment Referral screen displays, and displays only the referral just generated. Refer to Figure 6-37. Add Appointment Referral Screen, page 6-70.

Initiate the booking process

The Add Appointment Referral screen shows you which referral you are processing.

```
                              ADD APPOINTMENT REFERRAL
            Patient: PICARD,ZACHARY E                    FMP/SSN: 20/379-43-
6114
  Patient Category: USA ACTIVE DUTY OFFICER              Pat SSN:    379-43-
6114
           DOB/Age: 19 Feb 1966/35Y                          DDS: 20
      Patient Type: ACTIVE DUTY                              Sex: MALE
        MCP Status: ENROLLED
               PCM: ESPOSITO,FRANK M                  PCM Phone: 202 271-5850
Case Mgmt Provider:                                   Case Mgmt: NO

     Referral#  Date/Time         Provider            Specialty        Status
_____________________________________________________________________________
__
     200100057                                       DERMATOLOGY




_____________________________________________________________________________
__
Select (I)nterview/Referral, (P)rovider, (B)ook, (O)utputs, (D)elete,
       or (Q)uit ADD APPOINTMENT REFERRAL: B//
```

Figure 6-37. Add Appointment Referral Screen

Press <Return> to accept the default to (B)ook the appointment.

The MTF Booking Search Criteria screen displays. Refer to Figure 6-38. MTF Booking Search Criteria Screen, page 6-71.

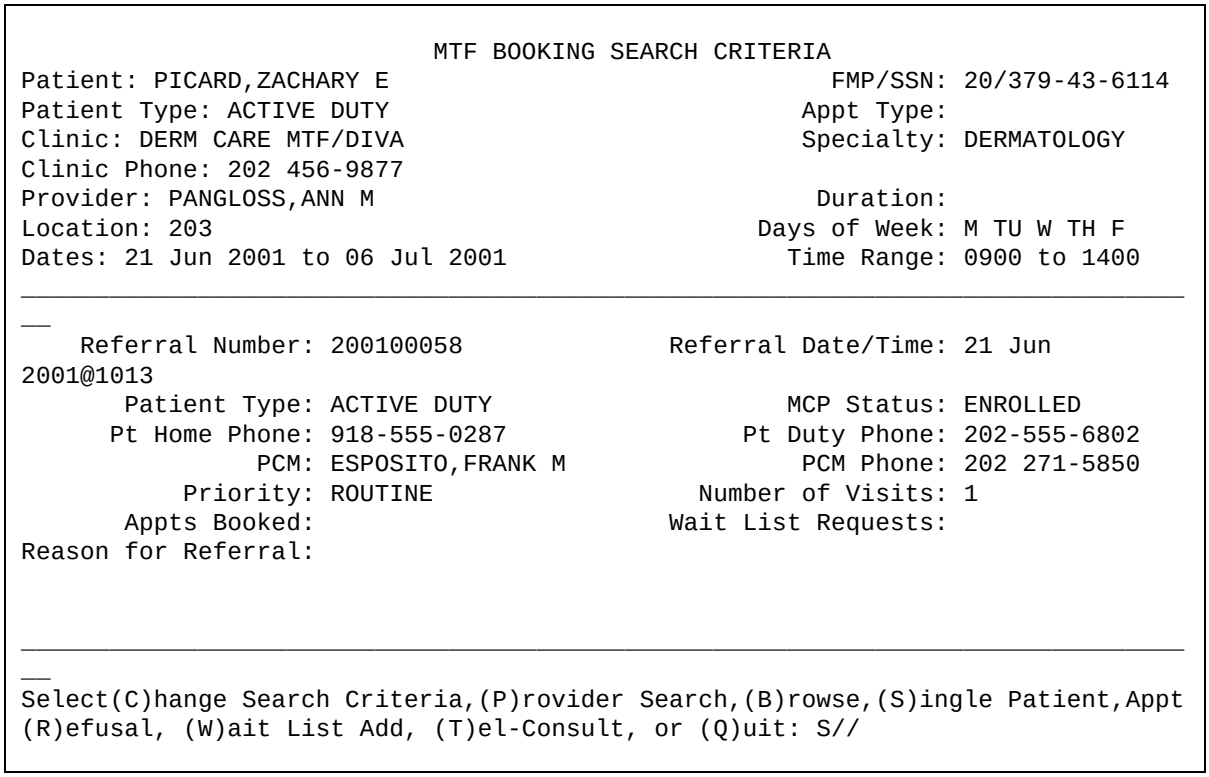

Figure 6-38. MTF Booking Search Criteria Screen

The Display Window displays the current demographic, provider, and referral information for the selected patient and selected provider from CHCS.

The Select Window displays information for the selected referral. This screen is view only.

The Interact Window displays the action bar, which contains the following actions:

- **(C)hange Search Criteria -** Changes the search appointment criteria for the referral requested. These criteria changes are limited to the Appointment Type, Time Range, Days of the Week, and Duration fields.

- **(P)rovider Search -** Selects the type of Provider Search to be performed, e.g., MTF, External, Non-network.

- **(B)rowse -** Searches the specified provider's schedule for a specific day to locate and display bookable appointment slots. This search is not limited to locating open appointment slots, but also locates and displays booked, frozen, wait listed, and canceled appointment slots. Use the Browse action to join slots, split slots, overbook, or change the appointment.

- **(S)ingle Patient -** Books one or more appointments, with the specified appointment type, for the designated MTF provider in a specified clinic, on one or more days for the specified patient. If no appointment type was entered, all available appointments for that provider are displayed. This search is confined to open slots only.

- **Appt (R)efusal -** Enters a patient's appointment refusal. An appointment refusal may be entered without selecting an appointment or creating a formal referral.

- **(W)ait List Add -** Adds this patient to the Wait List for the specified MTF place of care linked to the referral (only available if the specified clinic maintains an active Wait List).

- **(T)el-Consult -** Documents a patient telephone call to a provider regarding a booked or pending appointment linked to a referral.

(Q)uit - Quits the MTF Booking Search Criteria screen and return to the Modify Appointment Referral screen.

1. Press <Return> to accept the (S)ingle Patient default action.

2. The MTF Single Patient Booking screen displays showing the provider's open appointment slots, beginning with the first open slot. Refer to Figure 6-39. MTF Single Patient Booking Screen, page 6-73.

   The Select Window shows the day of the week, time, date and appointment type for the provider's available appointments. The 1/0 at the right of each appointment slot, indicates that only one patient can be booked into the slot and, to date, no patients have been booked into the slot.

   Had you entered a specific appointment type earlier at the *Select APPT TYPE* prompt, only open appointments of that type would display.

```
                          MTF SINGLE PATIENT BOOKING
Patient: PICARD,ZACHARY E                              FMP/SSN: 20/379-43-6114
Patient Type: ACTIVE DUTY                            Appt Type:
Clinic: DERM CARE MTF/DIVA                           Specialty: DERMATOLOGY
Clinic Phone: 202 456-9877
Provider: PANGLOSS,ANN M                              Duration:
Location: 203                                      Days of Week: M TU W TH F
Dates: 21 Jun 2001 to 06 Jul 2001                    Time Range: 0900 to 1400
_____________________________________________________________________________
__
   FRI 0800 22 Jun 01 NEW    1/0
   FRI 0830 22 Jun 01 NEW    1/0
   FRI 0900 22 Jun 01 NEW    1/0
   FRI 0930 22 Jun 01 NEW    1/0
   FRI 1000 22 Jun 01 NEW    1/0
   FRI 1030 22 Jun 01 NEW    1/0
   FRI 1100 22 Jun 01 NEW    1/0
   FRI 1130 22 Jun 01 NEW    1/0
+  FRI 1300 22 Jun 01 CON    1/0
_____________________________________________________________________________
__
Use SELECT key to select appointment(s) to be booked
```

Figure 6-39. MTF Single Patient Booking Screen

The Display Window displays current patient demographic information and referral information for this booking search from the data in CHCS for this appointment search.

The Select Window displays the available appointments for the selected MTF provider.

The Interact Window displays the message telling you to select the appointment(s) to be booked.

1. Position the cursor next to the desired appointment and press <Select>, then press <Return>.

   The maximum number of appointments that you may select depends upon the number of visits entered for this specific referral. You entered this information on the Interview/Referral screen.

   At this time, if you have selected more appointments for booking than the number of visits allowed for this referral, the system displays an error message. You must deselect the excess number of appointment slots before you can continue. Deselect an appointment by positioning the cursor beside the appointment and pressing <Select> again.

If you previously entered an appointment type in your search criteria, only those types of appointments display on this screen (e.g., New). If you leave the appointment type field blank, all available appointments for the provider display, regardless of the appointment type specified in the provider/clinic profile (i.e., New, Consultation, and Follow-up).

Note: Whenever an appointment slot is selected for booking, the system checks to determine whether the proposed appointment conflicts with any previously booked appointment. If the proposed appointment conflicts with an existing appointment, the system displays a warning message about the type of conflict found:

Direct Conflict – An override is not allowed if an existing appointment is already scheduled for the same time.

Close Proximity – You may book the appointment if the proposed appointment is in close proximity to a pending appointment. A close proximity appointment is determined by the appointment interval field in the facility profile in number of minutes.

After the warning message displays, depending on the conflict type, the system prompts you to indicate whether to override this conflict warning in order to book the proposed appointment.

2. The File appointment screen displays. Refer to Figure 6-40. File Appointment Screen, page 6-75.

Book the appointment(s)

```
                                FILE APPOINTMENT
Patient: PICARD,ZACHARY E                          FMP/SSN: 20/379-43-6114
Patient Type: ACTIVE DUTY                        Appt Type:
Clinic: DERM CARE MTF/DIVA                       Specialty: DERMATOLOGY
Clinic Phone: 202 456-9877
Provider: PANGLOSS,ANN M                          Duration:
Location: 203                                  Days of Week: M TU W TH F
Dates: 21 Jun 2001 to 06 Jul 2001                Time Range: 0001 to 2400
_____________________________________________________________________________
__
   FRI 0800 22 Jun 01 NEW    1/0




_________________________________Select Slot #1 of
1_____________________________________
Select (B)ook appt, or (Q)uit FILE APPOINTMENT: B//
```

Figure 6-40. File Appointment Screen

Refer to explanation following Figure 6-11. File Appointment Screen, page 6-21, for a full explanation of this screen.

1. Press <Return> to accept the (B)ook Appt action.

2. The second File Appointment screen displays.

```
PATIENT APPOINTMENT: PICARD,ZACHARY E                          FILE APPOINTMENT

                        FRI 0800 22 Jun 01 NEW    1/0
     No reminder notice will be sent. Hand-carry Radiology/Patient records.
                 Clinic Message: Arrive 10 minutes early.
   Clinic/Appt Type Instructions:
                Provider Message:
 Provider/Appt Type Instructions:
                 Arrival Message: 10 minutes
            Registration Comment:

                     MEPRS Code: BAPA
              Requesting Service:
                     Referred By:
            Send Reminder Notice: NO
             Appointment Comment:
          Reason for Appointment:


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 6-41. File Appointment Screen (Continuation)

Refer to the explanation following Figure 6-12. Secondary File Appointment Screen, page 6-22, for a full explanation and steps for completing this screen.

After you complete this screen and file the data, the following message displays: *Appointment Booked* - and you return to the MTF Single Patient Booking screen. The system asks if you want to print a copy of the patient's appointments/Wait List requests.

Print patient's appointments/Wait List requests

Print appointment referral products

Book an appointment with an MTF provider

When you select the (M)TF action, the system searches for providers with an agreement type of either CON, MTF, PIC, or SUP, whose place of care has a location type of C (clinic) or S (same day surgery), and whose agreements and availability meet the other search requirements specified in the referral. Refer to Appendix A, Table A-4, for a list of the MTF provider agreement types along with the eligible patient types for each agreement type.

EXAMPLE: Book Active-Duty to Direct Care Provider

Example for Search: If the HCF enters an appointment referral for an enrolled Active-Duty patient (Patient Type = MCA) in order that the patient may receive specialty care with a Cardiologist (Specialty Types under Cardiologist includes Cardiologist and Cardiac Surgeon) in the La Jolla area (ZIP Code Combination = La Jolla or as defined in the ZIP Code Combination file = 92121, 92122 and 92123), the HCF would accept the default of MCA in the PATIENT TYPE field, Cardiologist in the SPECIALTY field, and La Jolla in the ZIP CODE field.

EXAMPLE: Active-Duty to Direct Care Provider

Example for Search: When the HCF elects (in the above example) to search for all active MTF providers with current agreements that not only meet the search criteria but also meet patient appointment preferences (for instance, the patient prefers an appointment on either Monday or Wednesday, between 0800 and 1000, with a female provider who speaks Spanish), the system first searches the MCP Provider file for all those female MCP providers with an agreement type of CON, MTF, or SUP with a provider specialty of either Cardiologist or Cardiac Surgeon, whose place of care ZIP Code is either 92121, 92122, or 92123, and who have an available appointment slot on Monday and/or Wednesday for the date range entered. If no date range is entered, the system, defaults to today plus six weeks.

When the list displays, any provider who speaks Spanish has a tilde (~) displayed next to her name. These providers are listed in ZIP-Code order and within each ZIP Code by first available appointment.

Note: MTF providers with an agreement type of PIC do not appear on the provider list as those providers do not see active-duty patients.

Access the AHCF option

Select the patient

Review current DEERS eligibility

Review patient demographics

Enter appointment referral/patient preference data

Select an MTF provider

View provider detail

Initiate the booking process

Book the appointment(s)

Print patient's appointments/Wait List requests

Print appointment referral products

Access the AHCF option

Select the patient

Review current DEERS eligibility

Review patient demographics

Enter appointment referral/patient preference data

Assume the first five steps above have already been completed.

Select an MTF provider

Refer to Section 6.1.3.2 Find a Provider, page 6-59.

Perform the following actions beginning at the Provider Search screen and action bar (Refer to Figure 6-34. Provider Search Screen, page 6-65):

1. Enter “M” to access the (M)TF search action.

2. The system prompts you to select appointment type.

3. Enter appointment type.

   This requested appointment type must match the appointment types that are defined in the Master Appointment Type file and in the individual clinic/place of care and provider profiles (i.e., New, Consultation, or Follow-up). If you press <Return> the system searches for all appointment types for the MTF providers with the specialty type and location for which you are searching.

4. The Provider Search Select Window displays all MTF providers with the specialty type, location, and appointment type matching your search criteria. The first available appointment for each provider is also displayed. Refer to Figure 6-42. Provider Search Screen (with MTF Providers Displayed in the Select Window), page 6-80.

View provider detail

```
                                PROVIDER SEARCH
           Patient: PICARD,ZACHARY E                FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER         Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                     DDS: 20
      Patient Type: ACTIVE DUTY                         Sex: MALE
        MCP Status: ENROLLED
               PCM: ESPOSITO,FRANK M              PCM Phone: 202 271-5850
Case Mgmt Provider:                               Case Mgmt: NO
          Specialty: DERMATOLOGY                  Appt Type:
           Location: 203
         Start Date: 21 Jun 2001                  Stop Date: 06 Jul 2001
       Days of Week: M TU W TH F           Number of Visits: 1
           Priority: ROUTINE              Gender Preference:
           Language:                            Primary OHI: NOT ASSIGNED

    Provider         CS Cat   Agr Place of Care   Zip     1st Available Appt
_____________________________________________________________________________
__
    PANGLOSS,ANN M   B  MD    MTF DERM CARE MTF   20307   22 Jun 2001@0800
    PANACHE,BASIL M     MD    MTF DERM CARE MTF   20307   22 Jun 2001@0800
    PANTOUM,CAROL M  E  MD    MTF DERM CARE MTF   20307   22 Jun 2001@0800
+   PARAMOUNT,DOUGL  B  MD    MTF DERM CARE MTF   20307   22 Jun 2001@0800
_____________________________________________________________________________
__
Use the SELECT key to Select the Provider to whom to refer the patient
Press F9 to view Schedule, Discount Summaries, Place of Care, or Watch Codes
```

Figure 6-42. Provider Search Screen (with MTF Providers Displayed in the Select Window)

Refer to Figure 6-35. Provider Search Screen, page 6-66, and accompanying explanation of the Provider Search screen and the <F9> function.

Initiate the booking process

1. Use the down-arrow key to position the cursor next to the desired provider name. When the cursor is positioned, press <Select>.

   You immediately return to the Appointment Referral screen, except now the default action is “B” for (B)ook. The referral number and specialty type displays in the Select Window. A message just above the action bar tells you the Provider eligibility dates. Refer to Figure 6-43. Add Appointment Referral Screen with Provider Eligibility Dates, page 6-81.

```
                          ADD APPOINTMENT REFERRAL
          Patient: PICARD,ZACHARY E              FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER      Pat SSN:    379-43-6114
          DOB/Age: 19 Feb 1966/35Y                   DDS: 20
     Patient Type: ACTIVE DUTY                       Sex: MALE
       MCP Status: ENROLLED
              PCM: ESPOSITO,FRANK M           PCM Phone: 202 271-5850
Case Mgmt Provider:                           Case Mgmt: NO

     Referral#  Date/Time         Provider            Specialty        Status
_____________________________________________________________________________
__
     200100057                                        DERMATOLOGY



__________Provider eligibility dates are from 21 Jun 2001 to 06 Jul
2001_________
Select (I)nterview/Referral, (P)rovider, (B)ook, (O)utputs, (D)elete,
       or (Q)uit ADD APPOINTMENT REFERRAL: B//
```

Figure 6-43. Add Appointment Referral Screen with Provider Eligibility Dates

1. Press <Return> to accept the default (B)ook action on the Appointment Referral screen action bar.

   The MTF Booking Search Criteria screen displays. Refer to Figure 6-38. MTF Booking Search Criteria Screen, page 6-71. Accept the default (S)ingle Patient action.

   The schedule for the selected MTF provider displays on the MTF Single Patient Booking screen. Refer to Figure 6-39. MTF Single Patient Booking Screen, page 6-73.

2. Select the desired appointment.

   Choose the first appointment acceptable to the patient. If additional appointments are required, use the arrow keys to browse the list to select additional appropriate appointment slots. When finished, press <Return> to indicate you have completed your selections.

3. Press <Return> to indicate you have completed your appointment selections.

4. After you confirm the appointment slot selection(s), the File Appointment screen displays. Refer to Figure 6-40. File Appointment Screen, page 6-75.

Book the appointment(s)

1. Press <Return> to accept the (B)ook appt action.

2. The second File Appointment screen displays. Refer to Figure 6-41. File Appointment Screen (Continuation), page 6-76.

Print patient's appointments/Wait List requests

Print appointment referral products

Book an appointment with an external (civilian) provider and print directions to the provider's place of care

Scenario

You have already added an appointment referral for an SCD patient who needs to see an internal medicine provider located in ZIP code area 22203. You now need to locate a provider, book the appointment, and give the patient written directions to the provider's place of care.

Access the AHCF option

Select the patient

Review current DEERS eligibility

Review patient demographics

Enter Appointment referral/patient preference data

Find an external provider

View external provider detail

Initiate the booking process

Add an appointment slot

Book the appointment with the civilian provider

Print directions to the provider's place of care

Print patient's appointments/Wait List requests

Print appointment referral products

Access the AHCF option

Select the patient

Review current DEERS eligibility

Review patient demographics

Enter appointment referral/patient preference data

The first five steps listed in the box above are the same whether your patient needs an MTF provider or a civilian provider. Assume you've already completed those steps and you are now at the Add Appointment Referral screen. Refer to Figure 6-44. Add Appointment Referral Screen, page 6-85.

Find an external provider

The external (non-MTF) provider search allows you to search for network (non-MTF) providers with an agreement type of CON, NET, PEX, or SUP, and whose place of care has a location type of O (i.e., MCP non-MTF). Refer to Appendix A, Table A-5, External (Non-MTF) Provider Agreement Types and Eligible Patient Types.

An external provider is a member of the provider network, but is not located at the MTF. If there are no MTF providers who meet the search criteria for the appointment referral, the HCF searches the MCP Provider file for an external (civilian) provider who meets the search

criteria of agreement type, specialty, and ZIP code. The system lists external providers by percent discount, within discount by ZIP Code in random order.

EXAMPLE: Book Non-Active Duty to External Provider

Example for Search: If the HCF elects to search for all active external (Non-MTF) providers with current agreements that meet the search criteria, the system first searches the MCP Provider file for all those MCP providers with an agreement type of CON, NET, PEX, SUP, and NON with a provider specialty of either cardiologist or cardiac surgeon whose place of care ZIP Code is either 92121, 92122, or 92123.

When the list displays, the system first lists all external (non-MTF) network providers in ZIP-code order. At the end of the list, all non-network providers (that is, only service available and exception providers) with an agreement type of NON for the specialty type entered display regardless of the ZIP Code(s) or ZIP-Code location entered.

When the HCF elects to search for all active external providers with current agreements that meet the search criteria, the system searches the MCP Provider file for all external providers with the appropriate agreement types, specialty, and ZIP Code location. The external providers who meet the criteria appear in random order each time an HCF initiates a provider search. Schedules for external providers are not entered in CHCS. The HCF selects a provider and calls that provider to determine appointment availability. Once the HCF has booked an appointment with an external provider from the list and a new search has been initiated, the selected provider and the patient for whom an appointment was booked displays at the bottom of the list within the appropriate ZIP code. The picklist is grouped by ZIP Code and within ZIP Code, by discount summary.

```
                              ADD APPOINTMENT REFERRAL
          Patient: PICARD,ZACHARY E                    FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER            Pat SSN:    379-43-6114
          DOB/Age: 19 Feb 1966/35Y                         DDS: 20
     Patient Type: ACTIVE DUTY                             Sex: MALE
       MCP Status: ENROLLED
              PCM: ESPOSITO,FRANK M                  PCM Phone: 202 271-5850
Case Mgmt Provider:                                  Case Mgmt: NO

     Referral#  Date/Time         Provider            Specialty        Status
_____________________________________________________________________________
__
     200100058                                       INTERNAL MEDICI


_____________________________________________________________________________
__
Select (I)nterview/Referral, (P)rovider, (O)utputs, (D)elete,
       or (Q)uit ADD APPOINTMENT REFERRAL: P//
```

Figure 6-44. Add Appointment Referral Screen

1. Press <Return> to accept the default (P)rovider action.

   The Provider Search screen displays. Refer to Figure 6-45. Provider Search Screen, page 6-86.

```
                                 PROVIDER SEARCH
          Patient: PICARD,ZACHARY E                FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER        Pat SSN:    379-43-6114
          DOB/Age: 19 Feb 1966/35Y                     DDS: 20
     Patient Type: ACTIVE DUTY                         Sex: MALE
       MCP Status: ENROLLED
              PCM: ESPOSITO,FRANK M              PCM Phone: 202 271-5850
Case Mgmt Provider:                              Case Mgmt: NO
         Specialty: INTERNAL MEDICINE            Appt Type:
          Location: 22203
        Start Date: 21 Jun 2001                  Stop Date: 06 Jul 2001
      Days of Week: M TU W TH F           Number of Visits: 1
          Priority: ROUTINE              Gender Preference:
          Language:                            Primary OHI: NOT ASSIGNED
_____________________________________________________________________________
__


_____________________________________________________________________________
__
Search for (A)ppt Refusal,(P)rovider Name,(M)TF,(E)xternal,N(o)n-Network,
           or (Q)uit Provider Search:
```

Figure 6-45. Provider Search Screen

1. At the Provider Search Action Bar, enter “E” for External.

   A prompt to select appointment type displays in the Interact Window.

2. Press <Return> at the *Select APPT TYPE* prompt or enter the desired appointment type.

   The Provider Search screen displays for external providers. Refer to Figure 6-46. Provider Search Screen (for External Providers), page 6-86.

```
                                PROVIDER SEARCH
           Patient: PICARD,ZACHARY E                FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER         Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                     DDS: 20
      Patient Type: ACTIVE DUTY                         Sex: MALE
        MCP Status: ENROLLED
               PCM: ESPOSITO,FRANK M              PCM Phone: 202 271-5850
Case Mgmt Provider:                               Case Mgmt: NO
         Specialty: INTERNAL MEDICINE             Appt Type:
          Location: 22203
        Start Date: 21 Jun 2001                   Stop Date: 06 Jul 2001
      Days of Week: M TU W TH F            Number of Visits: 1
          Priority: ROUTINE               Gender Preference:
          Language:                             Primary OHI: NOT ASSIGNED

Provider            CS     Cat    Agr Place of Care   Zip    %Disc  Telephone
_____________________________________________________________________________
__
 PARLANCE,ABBAS     MD     NET    FARRAGUT CENTER     22203  CA-12% 703 544 1232
 PAESTUM,BARBARA    MD     NET    FARRAGUT CENTER     22203  CA-12% 703 544 1232
 PAISLEY,CLIFTON    MD     NET    FARRAGUT CENTER     22203  CA-12% 703 544 1232
+PRINGLE,DIANE C    MD     NET    FARRAGUT CENTER     22203  CA-12% 703 544 1232
_____________________________________________________________________________
__
Use the SELECT key to Select the Provider to whom to refer the patient
Press F9 to view Schedule, Discount Summaries, Place of Care, or Watch Codes
```

Figure 6-46. Provider Search Screen (for External Providers)

The Provider Search screen has three windows:

The Display Window provides the demographic information for the patient.

The Select Window displays each provider name, CS, CAT, AGR, place of care, and ZIP Code. It includes two additional columns not included for the MTF provider. These are the % discount and the telephone number for the place of care. The discount rate applies to non-

MTF providers only. A contractor may record their discounts on CHCS. The phone number is included so the HCF can contact the provider's place of care for available appointments. Once the HCF has contacted the place of care, the HCF can create an appropriate appointment slot and book the appointment.

> **Note:** The external providers who meet the criteria appear in random order each time a HCF initiates a provider search. Once the HCF has booked an appointment with an external provider from the list and a new search has been initiated, the previous provider selected and for whom an appointment was booked displays at the bottom of the list within the appropriate ZIP code. The picklist is grouped by ZIP Code and within ZIP Code, by discount summary.

The Interact Window displays the message to either select the provider or press <F9> to view the discount summaries. place of care, or schedule.

View external provider detail

At this point in your provider search, you may want to review more specific information about provider discounts or place of care before you select a provider.

1. Use the down-arrow key to position the cursor next to the provider name. In this example, the cursor was moved to PEARY,ZACHARY C.

> **IMPORTANT:** Do not press <Select> until after you have viewed the Provider Discount Summary action bar.

2. Press <F9> (to access the Provider Discount Summary action bar).

   Actions on the Provider Discount Summary action bar are:

   - **(O)verall Summary -** Displays the Individual Provider Discount Summary screen, which displays the overall discount rate for the selected provider.

   - **(S)pecialty Exceptions -** Displays the Individual Provider Specialty Exceptions screen, which displays pricing exceptions for selected specialty care for this provider.

- **(C)PT Exceptions -** Displays the Individual Provider Procedure Exceptions screen, which displays pricing exceptions for specific medical procedures (CPT-4) performed by this provider.

- **(P)lace of Care -** Displays the Provider Group Places of Care screen, which displays directions to and comments about the place of care for this provider.

- **(Q)uit -** Quits the <F9> expansion window and returns to the Provider Search screen where you can continue your provider selection.

3. Press <Return> to accept the default to view the provider's overall summary.

   The MCP Individual Provider Discount Summary screen displays. Refer to Figure 6-47. MCP Individual Provider Discount Summary Screen, page 6-88.

```
                    MCP INDIVIDUAL PROVIDER DISCOUNT SUMMARY



      MCP Provider: PEARY,ZACHARY C
MCP Provider Group: FARRAGUT CENTER
-------------------------------------------------------------------------------
--
 Agreement  Effective                 Overall      FI
   Type       Date       Stop Date    Discount     Notified      Except   PCM
_______________________________________________________________________________
__
   NET      01 Jan 2001  01 Jan 2005  CA- 12%



_______________________________________________________________________________
__
Press <RETURN> to continue
```

Figure 6-47. MCP Individual Provider Discount Summary Screen

This screen includes provider name, provider group name, agreement type, effective start and stop dates of discount agreement, overall discount rate, the FI notification date of changes to the agreement, whether the provider has exceptions and if the provider is a PCM.

1. Press <Return> to continue and select the Specialty Exceptions action (if you don't want to continue, press <Shift>-<^> to return to the Non-MTF Booking Search Criteria action bar).

The Specialty Exceptions screen displays. Refer to Figure 6-48. MCP Individual Provider Specialty Exceptions Screen, page 6-90.

```
                MCP INDIVIDUAL PROVIDER SPECIALTY EXCEPTIONS


              MCP Provider: PEARY,ZACHARY C
         MCP Provider Group: FARRAGUT CENTER
--------------------------------------------------------------------------------
--    Specialty                                          Discount          FI
Code             Start Date    Stop Date       Fee   Percent    Notified
_____________________________________________________________________________
__
018              01 Jan 2001                   $00   08%




Press <RETURN> to continue
```

Figure 6-48. MCP Individual Provider Specialty Exceptions Screen

The details displayed for each of the specialty exception codes for the selected MCP provider and MCP provider group are: start and stop dates, discount fee or discount off the cost, and FI notified date (date FI notified of changes to specialty exceptions).

1. Press <Return> to continue, then select the CPT Exceptions action

   The CPT Exceptions screen displays. Refer to Figure 6-49. MCP Individual Provider Procedure Exceptions Screen, page 6-91.

```
                MCP INDIVIDUAL PROVIDER PROCEDURE EXCEPTIONS


              MCP Provider: PEARY,ZACHARY C
         MCP Provider Group: FARRAGUT CENTER
--------------------------------------------------------------------------------
--
    CPT-4                                            Discount          FI
    Code         Start Date    Stop Date           Fee   Percent    Notified
_____________________________________________________________________________
__
    43234        01 Jan 2001                       $225  00%




_______________________________No Procedure Exceptions
found_____________________________
Press <RETURN> to continue
```

Figure 6-49. MCP Individual Provider Procedure Exceptions Screen

The details displayed for each of the CPT (procedure) exceptions for the selected MCP provider and the MCP provider group are: start and stop dates, discount fee or percent of discount, and FI notified date (date FI notified of change to provider CPT-4 discount).

1. Press <Return> to continue.

2. Select the Place of Care action to display the Provider Group Places of Care screen, which gives directions to, and comments on, the provider's places of care. Refer to Figure 6-50. MCP Provider Group Places of Care, Page 1, page 6-91.

```
                        MCP PROVIDER GROUP PLACES OF CARE

Place of Care: FARRAGUT CENTER
Address: 221 Hanover Street                                  City: ARLINGTON
State: VIRGINIA                                          Zip Code: 22203
Phone: 703 544 1232
_____________________________________________________________________________
__
                        Directions to Place of Care

Located on Hanover Street near the corner of Waldorf and Woodlawn, one block
south of Curtis Memorial Pkwy.

                         Comments on Place of Care

  Handicapped parking and wheelchair access available.




_____________________________________________________________________________
__
Press <RETURN> to continue
```

Figure 6-50. MCP Provider Group Places of Care, Page 1

1. Press <Return> to continue.

   The provider's hours of service display. Refer to Figure 6-51. MCP Provider Group Places of Care, Page 2, page 6-92.

```
                        MCP PROVIDER GROUP PLACES OF CARE

Place of Care: FARRAGUT CENTER
Address: 221 Hanover Street                                  City: ARLINGTON
State: VIRGINIA                                          Zip Code: 22203
Phone: 703 544 1232
_____________________________________________________________________________
__
---------------------------------- Hours of Service --------------------------
--

                    Day of Week          AM              PM
                    MONDAY          0700 - 1200     1201 - 1700
                    TUESDAY         0700 - 1200     1201 - 1700
                    WEDNESDAY       0700 - 1200     1201 - 1700
                    THURSDAY        0700 - 1200     1201 - 1700
                    FRIDAY          0700 - 1200     1201 - 1700
                    SATURDAY        0800 - 1200     0000 - 0000


_____________________________________________________________________________
__
Press <RETURN> to continue
```

Figure 6-51. MCP Provider Group Places of Care, Page 2

1. Press <Return> to continue, then select the Quit action to return to the Provider Search screen. Refer to Figure 6-46. Provider Search Screen (for External Providers), page 6-86.

At the Provider Search screen:

2. Use the down-arrow key to position the cursor next to the same non-MTF provider name as previously selected, PEARY,ZACHARY C in this example, and press <Select>.

3. The Add Appointment Referral screen displays, and displays only the referral just generated. Refer to Figure 6-52. Add Appointment Referral Screen, page 6-93.

Initiate the booking process

The Add Appointment Referral screen shows you which referral you are processing.

```
                          ADD APPOINTMENT REFERRAL
           Patient: PICARD,ZACHARY E               FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER        Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                    DDS: 20
      Patient Type: ACTIVE DUTY                        Sex: MALE
        MCP Status: ENROLLED
               PCM: ESPOSITO,FRANK M             PCM Phone: 202 271-5850
Case Mgmt Provider:                              Case Mgmt: NO

     Referral#  Date/Time         Provider          Specialty        Status
_____________________________________________________________________________
__
     200100057                                      INTERNAL MEDICINE




_____________________________________________________________________________
__
Select (I)nterview/Referral, (P)rovider, (B)ook, (O)utputs, (D)elete,
       or (Q)uit ADD APPOINTMENT REFERRAL: B//
```

Figure 6-52. Add Appointment Referral Screen

1. Press <Return> to accept the default to (B)ook the appointment.

   The Non-MTF Booking Search Criteria screen.
   Refer to Figure 6-53. Non-MTF Booking Search Criteria Screen, page 6-94.

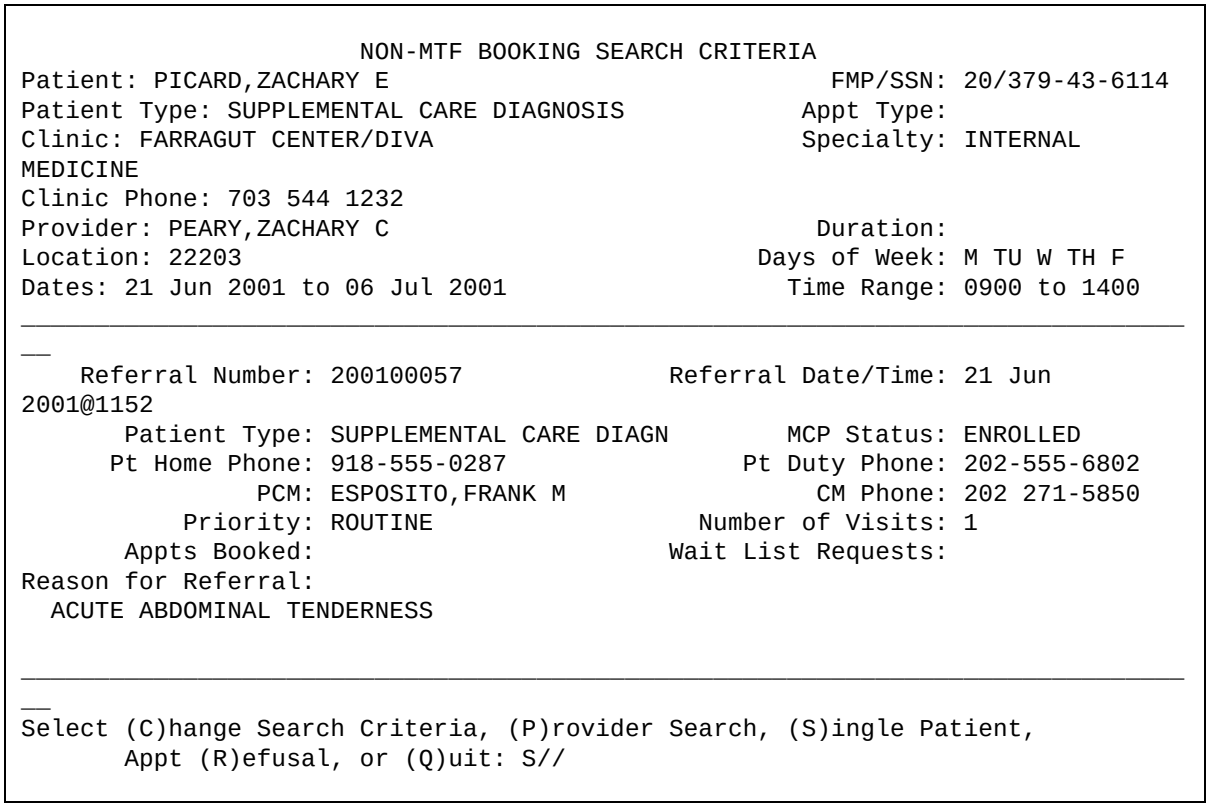

Figure 6-53. Non-MTF Booking Search Criteria Screen

The Non-MTF Booking Search Criteria Screen has three windows:

The Display Window displays current patient demographic, provider, and referral information.

The Select Window displays referral information, which cannot be edited.

The Interact Window displays an action bar with the following actions:

- **(C)hange Search Criteria -** Changes the search criteria for the referral requested. These criteria changes are limited to the Appointment Type, Time Range, Days of the Week, and Duration fields. All other search criteria may be changed using the Interview/Referral screen.

- **(P)rovider Search -** Selects providers based on the type of provider search to be performed.

- **(S)ingle Patient -** Books one or more appointments, with the specified appointment type, for the designated external provider in a specified place of care, on one or more days for the specified patient.

– **Appt (R)efusal -** Documents a patient's refusal of an appointment.

– **(Q)uit -** Quits the Non-MTF Booking Search Criteria screen and returns to the Modify Appointment Referral screen.

1. Press <Return> to accept the default Single Patient Booking action.

Add an appointment slot

The Add An Appointment Slot screen displays. Refer to Figure 6-54. Add an Appointment Slot Screen, page 6-95. This screen creates a specific appointment slot in a dummy provider schedule maintained in CHCS only.

```
                          ADD AN APPOINTMENT SLOT
Patient: PICARD,ZACHARY E                          FMP/SSN: 20/379-43-6114
Patient Type: SUPPLEMENTAL CARE DIAGNOSIS          Appt Type:
Clinic: FARRAGUT CENTER/DIVA                       Specialty: INTERNAL MEDICINE
Clinic Phone: 703 544 1232
Provider: PEARY,ZACHARY C                          Duration:
Location: 22203                                    Days of Week: M TU W TH F
Dates: 21 Jun 2001 to 06 Jul 2001                  Time Range: 0900 to 1400
_____________________________________________________________________________
__




Select (A)dd appointments, or (Q)uit NON-MTF booking: A//
```

Figure 6-54. Add an Appointment Slot Screen

The Add an Appointment Slot screen has three windows:

The top Display Window displays current demographic information and referral information for this appointment referral.

The middle Select Window displays the appointment details. This window is blank at this point.

The bottom Interact Window displays an action bar with the following actions:

– **(A)dd -** Adds an appointment slot to the provider's schedule, then continues processing.

– **(Q)uit -** Quits non-MTF booking.

1. Press <Return> to select the default Add appointments action.

   The Add an Appointment Slot screen redisplays with the following message in the Select Window:

   Enter appointment date@time to be added to the provider's schedule or Press <RETURN> to continue.

2. Enter an appointment date@time in one of the following formats:

   22JUN01@0900
   22 JUN 2001@0900
   T+1@0900.

Note: You can add the number of appointment slots you specified in the *Number of Visits* field. If you try to add more, the system displays the following message at the bottom of the Add An Appointment Slot screen:

```
_______Number of appts selected EXCEEDS the number of visits allowed (n)_______
Use SELECT key to deselect the excessive appointments.
```

Refer to Figure 6-16. Non-MTF Booking - Add Screen, page 6-30, to create an open appointment slot. Refer to Add an appointment slot, page 6-29, for instructions on how to file the data.

The Add An Appointment Slot screen redisplays, showing the appointment slot you just added. Refer to Figure 6-55. Add an Appointment Slot 2, page 6-97.

```
                          ADD AN APPOINTMENT SLOT
Patient: PICARD,ZACHARY E                          FMP/SSN: 20/379-43-6114
Patient Type: SUPPLEMENTAL CARE DIAGNOSIS          Appt Type: NEW
Clinic: FARRAGUT CENTER/DIVA                       Specialty: INTERNAL MEDICINE
Clinic Phone: 703 544 1232
Provider: PEARY,ZACHARY C                          Duration:
Location: 22203                                    Days of Week: M TU W TH F
Dates: 21 Jun 2001 to 06 Jul 2001                  Time Range: 0900 to 1400
_____________________________________________________________________________
__
 * FRI 0900 22 Jun 01 NEW    1/0   30 MIN  OPEN
                   <---Enter appointment date@time




_____________________________________________________________________________
__
Enter appointment date@time to be added to the provider's schedule or
Press <RETURN> to continue.
```

Figure 6-55. Add an Appointment Slot 2

1. Press <Return> to book the newly created, preselected appointment slot.

Book the appointment with the civilian provider

The File Appointment screen displays. Refer to Figure 6-56. File Appointment Screen, page 6-98. The (B)ook Appt default allows you to formally record the appointment as booked for the patient. This is simply a record in CHCS that the appointment has been booked. It does not actually update the civilian provider's own schedule.

```
                             FILE APPOINTMENT
Patient: PICARD,ZACHARY E                          FMP/SSN: 20/379-43-6114
Patient Type: SUPPLEMENTAL CARE DIAGNOSIS          Appt Type: CONSULT
Clinic: FARRAGUT CENTER/DIVA                       Specialty: INTERNAL MEDICINE
Clinic Phone: 703 544 1232
Provider: PEARY,ZACHARY C                          Duration:
Location: 22203                                    Days of Week: M TU W TH F
Dates: 21 Jun 2001 to 06 Jul 2001                  Time Range: 0900 to 1400
_____________________________________________________________________________
__
   FRI 1000 22 Jun 01 CON    1/0   20 MIN  OPEN



_____________________________Select Slot #1 of
1_____________________________
```

```
Select (B)ook appt, or (Q)uit FILE APPOINTMENT: B//
```

Figure 6-56. File Appointment Screen

1. Press <Return> to accept the default (B)ook appt.

2. Complete the File Appointment screen.

   The File Appointment secondary screen displays with the cursor positioned at the MEPRS Code field. Refer to Figure 6-12. Secondary File Appointment Screen, page 6-22, for an example and explanation of the File Appointment secondary screen.

3. File the data.

   The following message displays: Appointment Booked, and a blank Add An Appointment Slot screen redisplays. The Add an Appointment Slot screen action bar allows you to (A)dd appointments, (P)rint directions, or (Q)uit NON-MTF booking.

Print directions to the provider's place of care

1. Press <Return> to accept the default (P)rint directions action on the Add an Appointment Slot action bar.

2. Enter device (printer name) where you want the directions to print.

   If you press <Return> at the *DEVICE* prompt instead of entering a printer name, the Place of Care Directions/Comments displays. Refer to Figure 6-57. Place of Care Directions, Screen 1 of 2, page 6-99.

3. Press <Return> to accept the right margin default of 80.

   The system prints/displays the providers' place of care information.
   Refer to Figure 6-58. Place of Care Directions/Comments, Screen 2 of 2, page 6-99.

```
                                                    21 Jun 2001@1353   Page 1
                      PLACE OF CARE DIRECTIONS/COMMENTS
Place of Care: FARRAGUT CENTER
================================================================================
==
            Patient: PICARD,ZACHARY E            FMP/SSN: 20/379-43-6114
           Provider: PEARY,ZACHARY C
     Appt Date/Time: 22 Jun 2001@0900

     Street Address: 221 Hanover Street
        City, State: ARLINGTON, VA
                Zip: 22203
  Appt Contact Name: Appointment Clerk
          Telephone: 703 544 1232

Place of Care Hours: From  To   From  To
              Monday  0700 1200  1201 1700
             Tuesday  0700 1200  1201 1700
           Wednesday  0700 1200  1201 1700
            Thursday  0700 1200  1201 1700
              Friday  0700 1200  1201 1700
            Saturday  0800 1200


Press <RETURN> to continue
```

Figure 6-57. Place of Care Directions, Screen 1 of 2

```
                                    21 Jun 2001@1359   Page 2
                                      PLACE OF CARE DIRECTIONS/COMMENTS
Place of Care: FARRAGUT CENTER
================================================================================
==

         Directions:
Located on Hanover Street near the corner of Waldorf and Woodlawn, one block
south of Curtis Memorial Pkwy.

           Comments:
Handicapped parking and wheelchair access available.


Press <RETURN> to continue
```

Figure 6-58. Place of Care Directions/Comments, Screen 2 of 2

As soon as the Place of Care Directions/Comments have been printed, the system returns to the Add an Appointment screen, where you can either add another appointment referral or quit the Non-MTF booking process.

Print patient's appointments/Wait List requests

If you choose to quit, the system asks if you want to remind the patient of other appointments/Wait List requests. Refer to Print Patient's Appointment(s)/Wait List Requests, page 6-24, for details.

Print appointment referral products

Refer to Section 6.1.3.3 Print Appointment Referral Products, page 6-102; Figure 6-59. Provider Search Screen with Non-Network Providers, page 6-102; and Section 6.4 Health Care Finder Output Products And Reports, page 6-132.

Book an appointment with a non-network provider

Non-network providers are those providers with an agreement type of NON, who offer no discount (zero percent discount). These providers include Only-Service-Available (OSA) providers and exception providers, as well as non-network specialists who have no agreements with the government. Refer to Appendix A, Table A-6, for a list of non-network/exception provider agreement types along with the eligible patient types that a non-network provider may see.

An OSA provider is a non-network provider who provides a service (such as heart transplants) that is not available to the patients within the network. That provider is the only provider of that care in the area.

If a patient has an existing condition (such as a retiree who suffered a major stroke prior to enrolling to MCP) and the PCM agrees that the patient may continue to see the specialist for continuity of care, the provider could be assigned as the patient's case manager for the specified specialty type. This provider would be considered an exception provider. An exception provider with an agreement type of NON may be a case management provider.

EXAMPLE: All Active Non-Network Providers with Current Agreements

Example for Search: When the HCF elects to search for all active Non-Network providers with current agreements that meet the search criteria, the system first searches the MCP provider file for all those MCP providers with an agreement type of NON with the required provider specialty regardless of ZIP Code. If no date range is entered, the system defaults to today plus six weeks.

The system lists only those Non-Network providers (including, OSA and Exception providers) with an agreement type of NON for the specialty type entered regardless of the ZIP Code(s) or ZIP-Code location entered.

To book appointments with a non-network provider, follow the same steps for booking appointments with network external (civilian) providers.

Note that the Provider Search screen shows NON as the agreement type and the %Disc (percent discount) column is blank. Refer to Figure 6-59. Provider Search Screen with Non-Network Providers, page 6-102.

```
                                  PROVIDER SEARCH
           Patient: BLITON,JERALD                        FMP/SSN: 20/278-55-5025
  Patient Category: USA RET TDRL OFFICER                 Pat SSN:    278-55-5025
           DOB/Age: 01 Jan 1960/37Y                          DDS: 20
      Patient Type: MCP/CHAMPUS ELIGIBLE                     Sex: MALE
        MCP Status: ENROLLED
               PCM: CLASSY MEDICAL CARE               PCM Phone: 619-535-7116
Case Mgmt Provider:                                   Case Mgmt: YES
         Specialty: CARD                              Appt Type:
          Location: SAN DIEGO
        Start Date: 01 Apr 1997                       Stop Date: 16 Apr 1997
      Days of Week: M TU W TH F                Number of Visits: 1
          Priority: ROUTINE                   Gender Preference:
          Language: SPANISH                         Primary OHI: CALIFORNIA
CARE

    Provider         CS Cat   Agr Place of Care   Zip   %Disc   Telephone
_____________________________________________________________________________
__
    BARTON,FRANK       OTH    NON NONNETWORK CARD 92021 CA      234-2345
    CASTLE,RICHARD     OTH    NON OUTSIDE CARDIOL 98014 CA      234-0983
    STEVENS,BRIAN      OTH    NON OUTSIDE CARDIOL 98014 CA      234-0983
+   SHELTON,JAMES      OTH    NON OUTSIDE CARDIOL 98014 CA      234-0983
_____________________________________________________________________________
__
Use the SELECT key to Select the Provider to whom to refer the patient
Press F9 to view Schedule, Discount Summaries, Place of Care, or Watch Codes
```

Figure 6-59. Provider Search Screen with Non-Network Providers

6.1.3.3 Print Appointment Referral Products

When you accept the default (O)utputs action, the Generate Appointment Referral Products screen displays. Refer to Figure 6-60. Generate Appointment Referral Products Screen, page 6-102.

```
                    GENERATE APPOINTMENT REFERRAL PRODUCTS
           Patient: PICARD,ZACHARY E                    FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER             Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                         DDS: 20
      Patient Type: ACTIVE DUTY                             Sex: MALE
        MCP Status: ENROLLED
               PCM: ESPOSITO,FRANK M                PCM Phone: 202 271-5850
Case Mgmt Provider:                                 Case Mgmt: NO

     Referral#  Date/Time         Provider            Specialty        Status
_____________________________________________________________________________
__
    200100057                                       DERMATOLOGY

_____________________________________________________________________________
__
Select (E)nrollment Form, (M)embership ID, (C)are Authorization,
       (P)atient Label, Provider (L)abel, or (Q)uit Products: C//
```

Figure 6-60. Generate Appointment Referral Products Screen

The Generate Appointment Referral Products screen has three windows:

The Display Window displays current patient demographic, provider, and referral information about the referral being processed.

The Select Window displays the current referral information. It is display only and cannot be edited.

The Interact Window contains an action bar with the following actions:

- **(E)nrollment Form -** Generates an enrollment form if the patient is an enrollee. This form cannot be printed to the terminal screen.
- **(M)embership ID -** Generates an embossed MCP membership ID card if the patient is an enrollee. The system does not allow the print request for the embosser card to be sent to a standard printer. The site must have a special embosser machine to generate these

cards. After you enter the embosser format name, the system automatically gathers the information needed for this type of membership card.

> **Note:** Refer to Appendix A. for Instructions for customizing the Membership ID card for your site.

- **(C)are Authorization Form -** Generates a CAF. This selection appears on the action bar whether or not the current referral has an appointment linked to it.
- **(P)atient Label Form -** Generates mailing labels with the specified patient's name and address. These labels are used mainly for sending enrollment forms to the patient. The system does not allow you to print the patient label to the terminal screen or to a standard printer.
- **Provider (L)abel Form -** Generates mailing labels with the name and address of the referred to provider. These labels are used mainly for sending a Care Authorization Form to the provider. The Provider Label action appears on the action bar only if the current referral has at least one appointment linked to it. The system allows you to print this to a standard printer, but not to the terminal screen.
- **(Q)uit Products Form -** Quits the Generate Appointment Referral Products action and returns to the Add Appointment Referral screen.

These products can also be generated from the Outputs Products Menu (OHCF) option on the Health Care Finder Menu.

An HCP creating referrals and/or booking appointments linked to a specific referral can produce the appropriate individualized MCP CAF prior to booking an appointment. The system prints the appropriate standard text for the type of beneficiary on the CAF. Sites may edit the text of the form for each type of beneficiary. The system determines which text to print based on the beneficiary's MCP patient type. Refer to Figure 6-61. Care Authorization Form, Page 1, page 6-106, for an example of the CAF.

6.1.3.3.1 Print the Care Authorization Form

1. Press <Return> to accept the default (C)are Authorization action.

   You can also access Output Products from the Output Products (OHCF) option on the Health Care Finder Menu (HMCP) and from the Non-MTF Booking action bar (C(a)re Auth Form).

2. When you accept the default (C)are Authorization action, the following three prompts display at the bottom of the Generate Appointment Referral Products screen:

   Send Patient Records? No//
   Send Radiology Records? No//
   Send Lab Results? No//

   The default for all three prompts is "No." Enter "Y," if any of these records are required by the referred-to provider.

3. Enter the name of the printer where you want the CAF to print and accept the default right margin of 80.

4. Press <Return> at the *DO YOU WANT TO FREE UP THIS TERMINAL? NO//* prompt.

The CAF prints to the printer you indicated (refer to Figure 6-61. Care Authorization Form, Page 1, page 6-106; and Figure 6-62. Care Authorization Form, Page 2, page 6-106), and you return to the Generate Appointment Referral Products action bar where you can print other output products.

The bold print paragraph (refer to Figure 6-61. Care Authorization Form, Page 1, page 6-106) is site-definable through the MCP Form Text Enter/Edit (FORM) option (**Menu Path:** PAS System Menu → M → FMCP → ETAB → FORM). Refer to Section 2.1.1.4 MCP Forms Text Enter/Edit (FORM). Text may be defined separately for each type of beneficiary, i.e., active-duty, CHAMPUS-eligible, Medicare, and direct-care-only (not Medicare).

```
TRAINING MEDICAL TREATMENT FACILITY                          21 Jun 2001@1307
Personal Data - Privacy Act of 1974 (PL 93-579)
MCP CARE AUTHORIZATION FORM
================================================================================
==
Referral Number: 200100057                   Date/Time Issued:  21 Jun
2001@1300
        Patient: PICARD,ZACHARY E                      FMP/SSN: 20/379-43-6114

Patient Category: USA ACTIVE DUTY OFFICER                 Pat SSN: 379-43-6114
         DOB/AGE: 19 Feb 1966/35Y                             DDS: 20
       Home Phone: 918-555-0287                       Duty Phone: 202-555-6802
    Patient Type: ACTIVE DUTY                         MCP Status: ENROLLED
     Primary OHI: NOT ASSIGNED                      Sponsor Rank: CAPTAIN
     Referred To:


       PEARY,ZACHARY C
       FARRAGUT CENTER
       221 Hanover Street
       ARLINGTON, VA  22203

ACTIVE DUTY MCP ENROLLED

This Care Authorization covers necessary specialty care directed by the
primary care provider and authorized by the Primary Care Manager. The
care covered may be provided either within the MTF or by one of the
civilian network providers.

As a MCP HMO Option participant, the patient is responsible for cost
shares accrued during this episode of care.

Referred By: ESPOSITO,FRANK M              Referring Provider Phone: 202 427-
1281
                                           Referring Provider Fax #:
        HCF: GARFIELD,JANE                                HCF Phone: 202 555-
1111

Reason For Referral:
   Suspicious skin lesions



Provisional Diagnosis:
   172.5      MALIG MELANOMA TRUNK

Referral Procedure:
   17010       DESTRUCTION ANY METHOD BENIGN LESIONS COMPLICATED LESION(S)



 Authorization Begin Date: 21 Jun 2001 Authorization End Date: 06 Jul 2001
                  Priority: ROUTINE
```

Figure 6-61. Care Authorization Form, Page 1

```
TRAINING MEDICAL TREATMENT FACILITY                                21 Jun
2001@1307

                  Personal Data - Privacy Act of 1974 (PL 93-579)
                           MCP CARE AUTHORIZATION FORM
================================================================================
==
  Referral Number: 200100057                   Date/Time Issued:  21 Jun
2001@1300
         Patient: PICARD,ZACHARY E                      FMP/SSN: 20/379-43-6114
Number of Visits: 1
  Appt Date/Time: 22 Jun 2001@0900
      Send Patient Records: YES
    Send Radiology Records: NO
          Send Lab Results: NO
   Authorization Signature: FRANK M. ESPOSITO FNP
               MCP Office: OFFICE OF HEALTH CARE FINDER
           Street Address: 678 DUPONT CIRCLE
                     City: WASHINGTON
                    State: DC
                 Zip Code: 20307
             Office Phone: (442)234-0987
        Physician Findings:




      Note: Providers must generate a separate bill for each Referral.
```

Figure 6-62. Care Authorization Form, Page 2

> **Note:** The Physician Findings field is left blank for the referred to physician's comments.

6.1.3.4 Enter Appointment Refusals (EHCF)

Menu Path: PAS System Menu → M → HMCP → EHCF

- **Required Fields**

  Patient Name
  Specialty

Refusal Status
Refusal Reason

The Enter Appointment Refusals (EHCF) option enables you to enter appointment refusals for enrolled and non-enrolled patients without entering referral/patient interview data or booking an appointment. The system automatically creates a dummy referral and assigns a unique referral number to it to support system technical requirements. You can add multiple appointment refusals at one time for the specified patient. You can also view all refusals previously entered for that patient for the date range specified, including any appointment refusals entered using the PCM Booking, Appointment Referral Booking, and/or Non-Enrolled Booking options.

The system allows you to document either enrolled or non-enrolled patient refusals for patients who have refused appointments with either an MTF or external civilian provider. The system allows the HCF to enter an appointment refusal with or without booking an open appointment slot first.

In addition to documenting appointment refusals using the Enter Appointment Refusals (EHCF) option, you can document appointment refusals using the appointment refusals action on the MTF Booking Search Criteria action bar and Non-MTF Booking Search Criteria action for enrolled patients. These are accessed through the Appointment Referral Booking (AHCF) option on the Health Care Finder Menu. You can also document appointment refusals using the appointment refusal action on the PCM Booking Search Criteria screen action bar using the PCM Booking (PHCF) option on the Health Care Finder Menu. The appointment refusal action also appears on the Non-Enrolled Booking Search Criteria and Non-Enrolled Non-MTF Booking Search Criteria screens for non-enrolled patients. These are accessed through the Non-Enrolled Booking (NMCP) option on the Managed Care Program Menu.

Note: The clerk or HCF does not have to search for an appointment to log an appointment refusal. The clerk or HCF may be aware that there are no appointments in the MTF available that meet the patient's needs. The clerk or HCF may inform the patient of the situation, and log the refusal if the patient refuses to be referred to a network civilian provider outside the MTF.

- **Data Entry Process**

Document an appointment refusal by an enrolled patient

Scenario:

A followup appointment has been recommended and booked for an enrolled patient. You need to document the patient's refusal.

Access the EHCF option

Select refusal criteria to be changed

Select the patient

Review the Demographics Display screen

Enter refusal criteria

Enter appointment refusal

File the data

View or print appointment refusal data

Access the EHCF option

When you access the EHCF option, the Appointment Refusals screen displays. Refer to Figure 6-63. Appointment Refusals Screen (EHCF option), page 6-109.

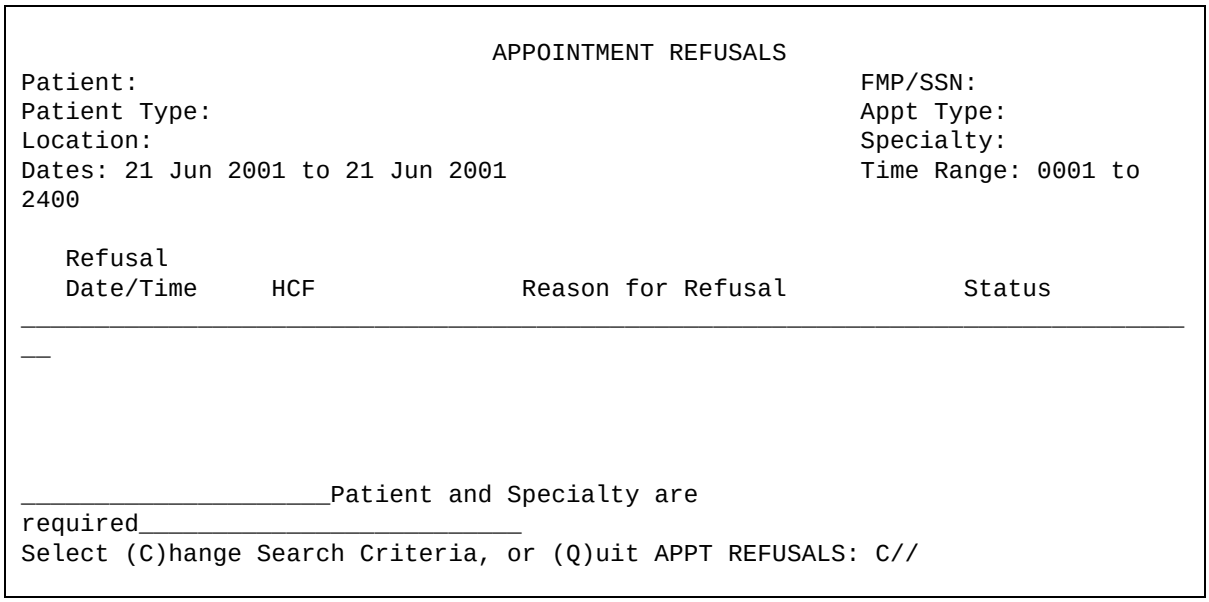

Figure 6-63. Appointment Refusals Screen (EHCF option)

The Appointment Refusals screen has three windows.

When you access the Appointment Refusals screen through the EHCF option, the top Display Window displays the patient, patient type, location, FMP/SSN, appointment type, and specialty without data. The Dates field contains the default of today's date and the Time Range field contains the default of 0001 to 2400.

When this screen is accessed using the PCM Booking, Appointment Referral Booking, and/or Non-Enrolled Booking options, the current demographics for the selected patient and the provider information for the selected appointment display in these fields.

The middle Select Window is blank, regardless of how you accessed the screen.

After you have entered a refusal, the Select Window displays:

- The date and time that the patient refused to have the appointment booked
- The name of the HCF who noted the patient's refusal
- The reason for the patient refusal. The Reason for Refusal field contains the coded reason for refusal if both a coded reason and a free-text reason are entered. If only a free-text reason is entered, the system displays as much of the free text as fits in the field
- The status of the refusal. This field shows whether the appointments refused were MTF declined, Civilian (Civ) declined, or Non-Network (Net) declined.

The bottom Interact Window displays the action bar. If you enter an appointment refusal through PCM Booking, Appointment Referral Booking, or Non-Enrolled Booking the action bar allows you to (A)dd Appt Refusal or (Q)uit Appt Refusals. When you enter an appointment refusal through the EHCF option, the action bar allows you to (C)hange Search Criteria or (Q)uit Appt Refusals.

Select the refusal criteria to be changed

At the EHCF Appointment Refusals action bar, press <Return> to accept the default (C)hange Search Criteria and the system adds selectable search criteria to the Select Window. Refer to Figure 6-64. Appointment Refusals with Selectable Search Criteria, page 6-110. Select the refusal data elements needed to accurately document the conditions associated with the refusal.

```
                              APPOINTMENT REFUSALS
Patient:                                                    FMP/SSN:
Patient Type:                                             Appt Type:
Location:                                                 Specialty:
Dates: 21 Jun 2001 to 21 Jun 2001                        Time Range: 0001 to
2400

   Refusal
   Date/Time     HCF              Reason for Refusal            Status
_____________________________________________________________________________
__
   Patient
   Specialty
   Patient Type
   Location
   Appointment Type
   Dates
   Time Range
   Default Search Criteria
_____________________Patient and Specialty are
required_____________________________
Use SELECT key to select SEARCH CRITERIA to be changed
```

Figure 6-64. Appointment Refusals with Selectable Search Criteria

1. Use the down-arrow key to position the cursor beside the criteria you want to change and press <Select>.

   When you press <Select>, an asterisk (*) displays beside your selection. To deselect the item, position the cursor beside the item and press <Select> again. You must select patient and specialty. The remaining items are optional.

2. When criteria are selected, press <Return>.

Select the patient

Review the Demographics Display screen

Refer to Review patient demographics, page 6-10. When you finish reviewing the Demographics Display screen, press <Return> to accept the default (C)ontinue action. The Appointment Refusals screen displays. Refer to Figure 6-65. Appointment Refusals Screen, page 6-111.

Enter refusal criteria

The Appointment Refusals screen collects data to document the refusal.

```
                              APPOINTMENT REFUSALS
Patient: PICARD,ZACHARY E                        FMP/SSN: 20/379-43-6114
Patient Type:                                    Appt Type:
Location:                                        Specialty:
Dates: 21 Jun 2001 to 21 Jun 2001                Time Range: 0001 to 2400

   Refusal
   Date/Time     HCF              Reason for Refusal            Status
_____________________________________________________________________________
02Apr01@0900     WILSON,JUDITH    REQUESTED PROVIDER NOT AVAIL  MTF DEC
05Feb01@0900     JONES,JAMES      DISTANCE TOO GREAT TO TRAVEL  NON-MTF


_____________________________________________________________________________
Select SPECIALTY:
```

Figure 6-65. Appointment Refusals Screen

You are prompted to enter each of the additional refusal criteria you selected, beginning with specialty type.

1. Specialty Type

   Enter the appointment specialty type the patient is refusing. The system returns the specialty type name and asks you to confirm that this is the correct specialty.

2. OK? YES//

Press <Return> to indicate the selection is correct. If you enter "N" for no at this prompt, the system returns to the *Select Specialty* prompt.

3. Patient Type

   If you selected patient type as a search criteria, enter one of the following codes:

MCA	MCP/Active Duty (i.e., active-duty, enrolled)
AD	Active Duty (i.e., active-duty, nonenrolled)
MCP	MCP/CHAMPUS Eligible (i.e., not active-duty, CHAMPUS-eligible, enrolled)
CHA	CHAMPUS (i.e., not active-duty, CHAMPUS-eligible, nonenrolled)
MCD	MCP/Non-CHAMPUS Eligible (i.e., not active-duty, not CHAMPUS-eligible, enrolled)
MED	MEDICARE (i.e., not active-duty, not CHAMPUS-eligible, enrolled or nonenrolled)
OTH	Other (i.e., direct care that is not CHAMPUS or MEDICARE, nonenrolled)
SCD	Supplemental Care Diagnostics (i.e., a one-time offsite care authorization for a specific test or procedure (e.g., MRI), enrolled or nonenrolled) **Note:** This patient type is new with CHCS Version 4.5.

4. Location

   You can enter either the ZIP code(s) for the area where the patient was to receive the medical care, or the geographical area (e.g., San Diego, Norfolk) already defined in the CHCS ZIP Code Combination file.

   If a ZIP Code is entered instead of a geographical area name, up to five different ZIP codes can be entered in this field at one time (separated by commas and no spaces).

   You can also enter a "wild card" ZIP code of the first three digits (e.g., 923). The system searches for all ZIP Codes that contain those first three digits.

5. Appointment Type

   You can enter the type of appointment your patient is refusing. Enter a double question mark (??) to view a list of appointment types.

6. Dates

   Enter start date and stop dates. You can enter dates in the past up through today's date at both the Start Date and Stop Date fields, such as T-1 or T-30. You cannot enter a date in the future and the stop date must be later than the start date. The default for both start and stop dates is today.

7. Time Range

   Enter inclusive earliest time and inclusive latest time. The default at the Inclusive Earliest Time field is 0001 and the default at the Inclusive Latest Time field is 2400. You can accept these defaults or narrow the search if you know the exact or approximate time of the appointment the patient is refusing.

8. Indicate whether you want the current criteria selections to be saved as your default selection criteria.

   After you've entered all search criteria you selected, the system asks if you want to save your selections as your default selection criteria. If you accept the "Yes" default at this prompt, the next time you need to search for an appointment, the search criteria data you just entered will be defaulted into the Appointment Refusals screen Display Window. If you enter "N," the search criteria fields in the Display Window revert to the system defaults.

Enter appointment refusal

When you finish entering your search criteria, the Appointment Refusals screen redisplays with additional actions on the action bar. Refer to Figure 6-66. Appointment Refusals Screen with Second Action Bar, page 6-114. This screen displays all refusals logged for the patient in order from most current to oldest.

```
                              APPOINTMENT REFUSALS
Patient: PHOTON,ZACHARY N                                  FMP/SSN: 20/353-30-
4614
Patient Type:                                              Appt Type:
Location:                                                  Specialty: DERMATOLOGY
Dates: 21 Jun 2001 to 21 Jun 2001                          Time Range: 0001 to
2400

   Refusal
   Date/Time     HCF              Reason for Refusal            Status
_____________________________________________________________________________
__
02Apr01@0900     WILSON,JUDITH    REQUESTED PROVIDER NOT AVAIL  MTF DEC
05Feb01@0900     JONES,JAMES      DISTANCE TOO GREAT TO TRAVEL  NON-MTF


_____________________________________________________________________________
Select (C)hange Search Criteria, (A)dd Refusal, (V)iew/Print History,
       or (Q)uit APPT REFUSALS: C//
```

Figure 6-66. Appointment Refusals Screen with Second Action Bar

The second Appointment Refusals action bar includes the following actions:

- **(C)hange Search Criteria** - Changes the search criteria and start over.
- **(A)dd Refusal -** Enters a new appointment refusal.
- **(V)iew/Print History -** Displays more detailed information about the appointment refusals for this patient. When this action is selected, the system displays the Appointment Refusal History screen with information about the current appointment refusal. You may also print this data.
- **(Q)uit APPT REFUSAL S -** Quits the Appointment Refusal process and returns to the Health Care Finder Menu.

When you enter A for (A)dd Refusal and press <Return>, the secondary Appointment Refusal screen displays with the cursor at the Refusal Status field. Refer to Figure 6-67. Appointment Refusal - Secondary Screen, page 6-115. Complete the data entry to document the refusal.

```
APPOINTMENT REFUSALS: 21 Jun 2001@150845                    APPOINTMENT REFUSAL

          Patient: PHOTON,ZACHARY N                    FMP/SSN: 20/353-30-4614
 Patient Category: USN RET LOS OFFICER                 Pat SSN:    353-30-4614
          DOB/Age: 09 Dec 1943/57Y                        DDS:
        Case Mgmt: NO                                     SEX: MALE
     Patient Type:                                 MCP STATUS:
              PCM:                                  PCM Phone:

================================================================================
=
  Referral Number:                          Refusal Date/Time: 21 Jun 2001@1508
        Specialty: DERMATOLOGY                  Location:
              HCF: Jane Garfield
   Refusal Status:
   Refusal Reason:
 Refused Provider:
   Refusal Reason: (Free Text)



      HCF Comment:


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 6-67. Appointment Refusal - Secondary Screen

1. Refusal Status

   Identifies whether the appointment refused was an MTF declined, a non-MTF declined (civilian network), or a Network declined appointment. Enter a double question mark (??) to display a picklist of acceptable values and use the down-arrow and <Select> keys to choose the appropriate value.

   MTF declined means the patient refused an appointment available at the MTF. Non-MTF declined means the patient refused an appointment available within the network but outside the MTF. Network declined means the patient refused all available appointments.

2. Refusal Reason

   Identifies the coded MCP appointment refusal reason that explains why the MCP patient refused an available appointment. Enter a double question mark (??) to display a picklist of acceptable values or enter the MCP appointment refusal reason

code or description. Use the down-arrow key to position the cursor next to the appropriate reason and press <Select>.

If the refusal status is “MTF declined,” choose from the following refusal reasons:

- Requested provider not available
- Appointment date/time unacceptable
- Unhappy with MTF service/provider(s)
- Distance too great to travel
- Wanted a civilian appointment.

If the refusal status is “Non-MTF” or “Network declined" choose from the following refusal reasons:

- Cost share too high
- Appointment date/time unacceptable
- Unhappy with group/provider
- Distance too great to travel
- Wanted an MTF appointment.

You may not add site-defined entries to the Refusal Reason file.

Note: If UNHAPPY WITH MTF SERVICE/PROVIDER(S) or UNHAPPY WITH GROUP PROVIDER is entered as the refusal reason, the cursor moves to the Refused Provider field where the HCF can enter the refused provider’s name. Otherwise, the cursor bypasses the Refused Provider field and moves to the Refusal Reason free-text field.

3. Refusal Reason (free-text)

   Word processing field you can use to enter a more detailed description of why the patient refused the appointment.

4. HCF Comment

   Enter additional comments about the MCP patient and why the specified patient may have declined the appointment.

File the data.

The initial Appointment Refusals screen redisplays. You can change the search criteria, add another appointment refusal, view the patient's refusal history or quit.

View or print appointment refusal data

When you choose the (V)iew/Print Refusal History action, the appointment refusal you just entered displays, and any other appointment refusals for this patient. The Interact Window instructs you to use <Select> to select one of the patient's individual appointment refusals to view or print or press <Return> to continue.

1. To select a refusal, position the cursor next to it and press <Select>, then press <Return>.

2. At the *Select Device* prompt, press <Return> or enter a printer name if you need a hard copy.

3. Press <Return> to accept the default of 80 at the *Right Margin* prompt.

4. The system displays or prints the appointment refusal. Refer to Figure 6-68. Appointment Refusal Printout, page 6-118. Press <Return>.

5. Exit the option.

Press <Return> until you reach the action bar where you can change the search criteria, add another refusal, view/print history, or quit appointment refusals.

```
APPOINTMENT REFUSALS: 21 Jun 2001@1537                    APPOINTMENT REFUSAL

         Patient: PHOTON,ZACHARY N                    FMP/SSN: 20/353-30-4614
Patient Category: USN RET LOS OFFICER                 Pat SSN: 353-30-4614
         DOB/AGE: 09 Dec 1943/57Y                         DDS:
       Case Mgmt: NO                                      SEX: MALE
    Patient Type:                                  MCP Status:
             PCM:                                   PCM Phone:
================================================================================
==
 Referral Number:                        Refusal Date/Time: 21Jun2001@1508
       Specialty: DERMATOLOGY                     Location:
             HCF: GARFIELD,JANE
  Refusal Status: MTF DECLINED
  Refusal Reason: APPOINTMENT DATE/TIME UNACCEPTABLE
Refused Provider:
  Refusal Reason:  (Free Text)


     HCF Comment:



Press <RETURN> to continue
```

Figure 6-68. Appointment Refusal Printout

6.2 Display Patient Appointments (DMCP)

Menu Path: PAS System Menu → M → DMCP

- **Security Keys**

  CPZ CCP needed by all MCP users. No other security keys required to access this option.

- **Required Fields**

  Patient Name
  Output Device

- **Application Description**

The Display Patient Appointments option allows you to display and/or print a patient's past, future, Wait List or specific date selected appointments. The system provides an Appointment Confirmation notice - a printed copy to remind the patient of the pending appointments. The system produces the notice in the clinic at the time the appointment is booked, thus making it available to hand to the patient if the appointment is made in person. All of the patient's pending appointments are listed with the necessary instructions for each. The system adds all patient Wait List requests to the end of the patient's future appointment file.

- **Data Entry Process**

Scenario

You have just booked a follow-up appointment for a patient who is present in the office. You want to give the patient a printed copy reminder of the appointment.

Access the DMCP option

Select the patient name

Select future, past, Wait List or specific-date appointments

Display or print the report

Display or print other family member appointments

Access the DMCP option

Select the patient name

Use your site's preferred method of patient lookup to enter the patient ID. Review the patient data returned by the system and press <Return> at the *OK? Yes* prompt if the information is correct.

Select future, past, Wait List or specific date appointments

1. When you press <Return> to verify that the system has found the correct patient, the system prompts you to select the type of appointments to display, either future, past, Wait List, or from a specific date forward. You can also quit the Display Patient Appointments option at this prompt. If you specify future appointments, or appointments from a specific date forward, the system also includes Wait List requests for the patient specified.

2. If you want to display/print appointments for a specific date, you are prompted to enter the specific date.

Display or print the report

1. Select DEVICE

   Press <Return> to display the list to your screen or enter a printer name to print a hard copy.

2. Right Margin: 80//

   Press <Return> to accept the default of 80.

The system displays the Display Patient Appointments screen or prints the data to the device you entered in Step 1. Refer to Figure 6-69. Display Patient Appointments, page 6-121.

```
                          DISPLAY PATIENT APPOINTMENTS

               Personal Data - Privacy Act of 1974 (PL 93-579)
             FUTURE APPOINTMENTS FOR PHOTON,ZACHARY N  20/353-30-4614
CLINIC/DIV                    PROVIDER      DATE/TIME          TYPE   STATUS
================================================================================
==
GEORGETOWN MED/DIVA           PUSHKIN,ZELD  02 Jul 2001@0800   FOL    BOOKED
                                        Arrive 10 min early


              WAIT LIST REQUESTS FOR PHOTON,ZACHARY N  20/353-30-4614
CLINIC/DIV                    TYPE   PRI  DATE IN      TARGET DATE  PROVIDER
================================================================================
==


                              NO WAIT LIST REQUESTS!
```

Figure 6-69. Display Patient Appointments

If the request is for future appointments or past appointments, the display/copy contains clinic, division, provider, date and time of the appointments, appointment type and status.

If the request is for Wait List requests, the display contains clinic, division, appointment type, priority, entry date (date in), target date, and provider.

If the specified patient was booked from the Wait List through the automatic booking function, the system lists this information beneath the appointment data.

Display or print appointments of other family members

When you press <Return> at the screen display, you are prompted to display other family members' appointment histories. When you display the appointment histories of other family members, the display patient appointments process repeats for each family member. Refer to Figure 6-70. Family Appointment History, page 6-122.

```
                        DISPLAY PATIENT APPOINTMENTS

               Personal Data - Privacy Act of 1974 (PL 93-579)
             FUTURE APPOINTMENTS FOR PHOTON,ZACHARY N  20/353-30-4614
CLINIC/DIV                     PROVIDER      DATE/TIME          TYPE   STATUS
================================================================================
==
GEORGETOWN MED/DIVA            PUSHKIN,ZELD  02 Jul 2001@0800   FOL    BOOKED
                                         Arrive 10 min early


              WAIT LIST REQUESTS FOR PHOTON,ZACHARY N  20/353-30-4614
CLINIC/DIV            TYPE   PRI  DATE IN      TARGET DATE  PROVIDER
================================================================================
==
FAMILY PRACTICE/ADIV  NEW    2    08 Feb 1996  09 Feb 1996  HENRY,JAMES
CARDIOLOGY CLINIC     NEW    2    08 Dec 1995  09 Dec 1995  ALEXANDER,NI
CARDIOLOGY CLINIC     FOL    2    14 Dec 1995  15 Dec 1995  PARKS,JAMES
Press <RETURN> to continue
Display/Print Appointment History of Other Family Members? NO// y  (YES)

     1   278555025 01  PHOTON,MARK     01/353-30-4614 16 Apr 1982 M
     *** Ward:  4B                     ADIV
     2   278555025 02  PHOTON,S        02/353-30-4614 09 Jun 1986 M
Type '^' to stop, or
Choose 1-5:
```

Figure 6-70. Family Appointment History

> **Note:** The system only recognizes patients booked under the same sponsor SSN as being members of the same family.

You exit the option and return to the Managed Care Program Menu.

6.3 Cancellation By Patient (CMCP)

There are two methods for canceling an appointment. You can cancel at the patient's request or at the facility's request. Canceling an appointment at the facility's request is not covered in this user guide.

Menu Path: PAS System Menu → M → CMCP

- **Security Keys**

  CPZ CCP needed by all MCP users. No other security keys required to access this option.

- **Required Fields**

  Patient Name

- **Application Description**

The Cancellation by Patient (CMCP) option allows you to cancel and, optionally, reschedule future appointments for an enrolled or non-enrolled patient who has an appointment with any MCP provider, without exiting from the Cancellation by Patient option. Appointments may have been booked through PCM, Non-Enrolled, Appointment Referral, or PAS booking. The system prompts you to enter a patient name and other selection criteria, then searches for all appointments, for the specified patient, that meet the search criteria. For each appointment slot found during the search, the system gives you the option of canceling only or of canceling and rescheduling.

> **Note:** This option allows you to reschedule an appointment slot only if the provider's agreement data has not been modified since the time that the original appointment was booked. To reschedule appointments with a patient's PCM, use the PCM Booking option.

When you have completed processing the appointments, the system allows you either to process appointments for another patient, or exit the option.

Note: When appointments are canceled using this option, the name of the user and the date/time of cancellation are stored in the Patient Appointment file and are displayed on the End-of-Day Processing report.

- **Data Entry Process**

Cancel an appointment at the patient's request

Scenario

You are an HCF working in the Service Center. A patient calls to cancel an appointment and does not wish to reschedule. You need to document the cancellation.

Access the CMCP option

Select search criteria to change

Select the patient

Review the Demographics Display screen

Enter cancellation search criteria

Search for appointment(s)

Select appointment(s) to cancel

Cancel or cancel/reschedule the appointment(s)

Access the CMCP option

The Cancellation by Patient Search Criteria screen displays with an action bar prompting you to change the search criteria, search for appointments that meet predefined search criteria, or to quit and exit the option. Refer to Figure 6-71. Cancellation by Patient Search Criteria Screen, page 6-125.

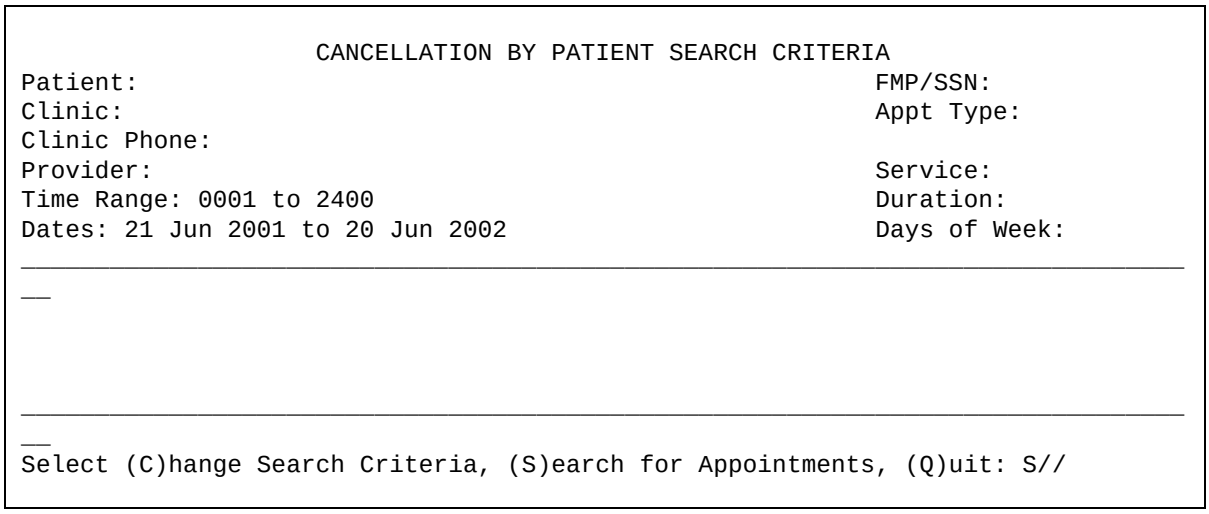

Figure 6-71. Cancellation by Patient Search Criteria Screen

The Cancellation by Patient Search Criteria screen has three windows:

The top Display Window contains the patient demographic, and provider information fields. These fields are blank, but fill in as the search criteria are defined. The Dates and Time Range fields contain system defaults, but they can be edited.

The middle Select Window is also blank.

The bottom Interact Window contains an action bar with the following actions:

- **(C)hange Search Criteria** - Changes the following fields:

  Patient
  Place of care
  Provider
  Time range
  Dates
  Appointment type
  Default search criteria.

- **(S)earch for Appointments -** Searches for appointments to cancel based upon the search criteria entered. If the patient name was not previously specified in the search criteria, the system prompts you for the patient name before searching for appointments to cancel.

- **(Q)uit -** Quits the cancel by patient process and returns to the Managed Care Program Menu.

Select the search criteria to change

When you select the (C)hange Search Criteria action on the Cancellation by Patient Search Criteria action bar, a list of selectable search criteria displays and you are prompted to select the criteria to enter/edit. Refer to Figure 6-72. Cancellation by Patient Search Criteria Screen with Selectable Search Criteria, page 6-126.

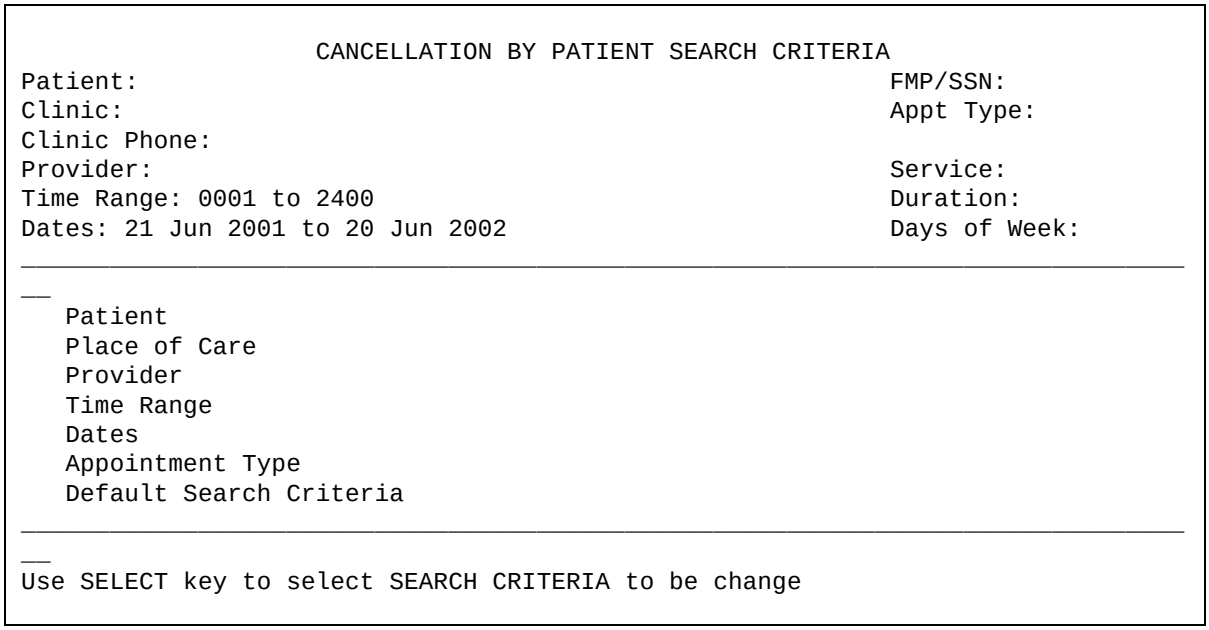

Figure 6-72. Cancellation by Patient Search Criteria Screen with Selectable Search Criteria

The patient name is required; the place of care, provider, time range, dates, and appointment type are optional. You can specify that the currently-selected search criteria become the default search criteria for further processing actions.

1. Use the down-arrow key to position the cursor beside the criteria you want to change and press <Select>.

   When you press <Select>, an asterisk (*) displays by your selection. To deselect the item, position the cursor beside the item and press <Select> again. You must select patient and specialty. The remaining items are optional.

2. When finished selecting, press <Return>.

Select the patient

Review the Demographics Display screen

Refer to Figure 6-3. Demographics Display Screen, page 6-11. When you finish reviewing the Demographics Display screen and press <Return> to continue, the Cancellation by Patient Search Criteria screen redisplays. Refer to Figure 6-73. Cancellation by Patient Search Criteria Screen, page 6-127.

Enter cancellation search criteria

This criteria identify the appointment to cancel.

```
                    CANCELLATION BY PATIENT SEARCH CRITERIA
Patient: PICARD,ZACHARY E                          FMP/SSN: 20/379-43-6114
Clinic:                                            Appt Type:
Clinic Phone:
Provider:                                          Service:
Time Range: 0001 to 2400                           Duration:
Dates: 21 Jun 2001 to 20 Jun 2002                  Days of Week:
_____________________________________________________________________________
__




_____________________________________________________________________________
__
Select (C)hange Search Criteria, (S)earch for Appointments, (Q)uit: S//
```

Figure 6-73. Cancellation by Patient Search Criteria Screen

1. Select (C)hange Search Criteria, (S)earch for Appointments, (Q)uit: S//

   Press <Return> to accept the default (S)earch for Appointments. You are prompted to enter/edit the values of the selected cancellation search criteria.

2. Clinic

   Optional. Enter the clinic name where the appointment is currently booked.

3. Provider

Optional. Enter the specific provider with whom the appointment is booked.

4. Time Range

   Enter inclusive earliest time and inclusive latest time. Optional. The default inclusive earliest time is 0001 and the default inclusive latest time is 2400. If you know the appointment in question is scheduled in the afternoon, you can change the inclusive earliest time to 1200 and the inclusive latest time to 1700, for example. If you know the appointment in question is scheduled for 0900, you can change the inclusive earliest time to 0900 and the inclusive latest time to 0900.

5. Dates

   Enter start date and stop date. The default start date is today and the default stop date is one year from today. You can enter specific dates or you can enter T + n (examples: T for today and T + 1 for tomorrow, T + 30 for thirty days from today). Neither the start data or stop date can be before today's date and the stop date must be later than the start date. If the year is omitted, the system assumes a future date.

6. Appt Type

   You can enter the specific appointment type (e.g., new, followup, consult). Enter a double question mark (??) at the *Select Appt Type* prompt to display a picklist of possible entries.

   As you enter search criteria, the data displays in the top Display Window fields on the Cancellation by Patient Search Criteria screen. When you finish entering the search criteria, the initial action bar redisplays. Refer to Figure 6-74. Cancellation by Patient Search Criteria Screen with Search Criteria Entered, page 6-129.

```
                    CANCELLATION BY PATIENT SEARCH CRITERIA
Patient: PHOTON,ZACHARY N                              FMP/SSN: 20/353-30-
4614
Clinic: DERM CARE MTF/DIVA                             Appt Type:New
Clinic Phone:
Provider: PANACHE,BASIL M                              Service:
Time Range: 0900 to 1600                               Duration:
Dates: 21 Jun 2001 to 21 Jul 2001                      Days of Week:
_____________________________________________________________________
__



_____________________________________________________________________
__
```

```
Select (C)hange Search Criteria, (S)earch for Appointments, (Q)uit: S//
```

Figure 6-74. Cancellation by Patient Search Criteria Screen with Search Criteria Entered

Search for appointment(s)

When you accept the default (S)earch for Appointments action on the initial action bar, the system searches for all appointments that meet the search criteria you entered. All appointments that meet the criteria displayed in the middle Select Window of the Cancel/Reschedule Patient Appointments screen. Refer to Figure 6-75. Cancel/Reschedule Patient Appointments Screen, page 6-129. You are prompted to select the one(s) to be canceled or rescheduled.

> **Note:** If there are no appointments for this patient during the specified times, a blank Cancellation by Patient Search Criteria screen displays with the following message: No appointments for this patient after the start date specified. If this is the case, you can either use the Change Search Criteria action on the action bar and enter new dates, or you can quit the screen and return to the Managed Care Program Menu.

Select appointment(s) to cancel

```
                    CANCEL/RESCHEDULE PATIENT APPOINTMENTS
Patient: PHOTON,ZACHARY N                                  FMP/SSN: 20/353-30-
4614
Clinic: DERM CARE MTF/DIVA                                 Appt Type: NEW
Clinic Phone: 202 456-9877
Provider: PANTOUM,C                                        Service:
Time Range: 0900 to 1600                                   Duration:
Dates: 21 Jun 2001 to 21 Jul 2001                          Days of Week:
_____________________________________________________________________________
__
   WED 0900 27 Jun 01 NEW    DCM    PANTOUM,C
   FRI 0900 29 Jun 01 NEW    DCM    PANTOUM,C



_____________________________________________________________________________
__
Use SELECT key to select appointments to be canceled/rescheduled
```

Figure 6-75. Cancel/Reschedule Patient Appointments Screen

1. Use the down-arrow key to position the cursor next to the appointment(s) you want to cancel, then press <Select>.

2. When you have selected appointments to cancel, press <Return>.

   The system highlights the first appointment you selected and displays a message telling you which option was used to book the appointment. The action bar now allows you to cancel or reschedule the appointment, skip to the next appointment you selected, or quit. Refer to Figure 6-76. Cancel/Reschedule Patient Appointments Screen Ready to Process First Selected Appointment, page 6-130.

Cancel or cancel/reschedule the appointment

```
                    CANCEL/RESCHEDULE PATIENT APPOINTMENTS
Patient: PHOTON,ZACHARY N                              FMP/SSN: 20/353-30-
4614
Clinic: DERM CARE MTF/DIVA                             Appt Type:NEW
Clinic Phone: 202 456-9877
Provider: PANTOUM,CAROL M                              Service:
Time Range: 0900 to 1600                               Duration:
Dates: 21 Jun 2001 to 21 Jul 2001                      Days of Week:
_____________________________________________________________________________
__
   WED 0800 27 Jun 01 NEW    DCM    PANTOUM,C
   FRI 0800 29 Jun 01 NEW    DCM    PANTOUM,C



_____________________________Select appointment #1 of
2___________________________________
This appointment was booked from Non-Enrolled Booking
Select (C)ancel, (R)eschedule,(S)kip,(V)iew, or(Q)uit CANCEL/RESCHEDULE:
```

Figure 6-76. Cancel/Reschedule Patient Appointments Screen Ready to Process First Selected Appointment

Actions on the Cancel/Reschedule Patient Appointments action bar:

– **(C)ancel** - Cancels an MTF appointment.

  If the appointment is a non-MTF appointment, the system prompts you to indicate whether the place of care has been notified of the cancellation. The system cancels the appointment only if the answer is affirmative.

In either case, if there is another appointment in the list, you return to the Search for Appointments action bar to process that appointment. If there are no more appointments, you return to the initial action bar.

– **(R)eschedule** - If the appointment is an MTF appointment, the MTF Booking Search Criteria screen displays and allows you to book new appointments. The system then cancels the original appointment. Refer to Figure 6-38. MTF Booking Search Criteria Screen, page 6-71.

  If you reschedule an MTF appointment without leaving the Cancellation by Patient option, the appointment status changes to Open and it becomes available for rebooking. Rebooking can be from the Wait List if the specified clinic has an active Wait List, through either PAS or MCP.

> **Note:** Refer to PAS: Appointment Booking, for further information on the process for rescheduling an appointment that has been canceled by the patient, and the process for rebooking the canceled appointment from the Wait List.

If the appointment is a non-MTF appointment, the Non-MTF Booking Search Criteria screen displays, where you can book a new appointment. The system then cancels the original appointment. Refer to Figure 6-38. MTF Booking Search Criteria Screen, page 6-71.

In either case, if there is another appointment in the list, the you return to the action bar where you can process the remaining appointments you selected. Refer to Figure 6-75. Cancel/Reschedule Patient Appointments Screen, page 6-129. If there are no more appointments, you return to the initial action bar. You can change the search criteria, process additional appointments for the same patient, change the search criteria and cancel or reschedule appointments for another patient, or quit the option and return to the Managed Care Program Menu.

– **(S)kip** - Bypasses the current appointment in the list. If the current appointment is the last, you advance to the first unprocessed appointment in the list. Otherwise, you advance to the next unprocessed appointment in the list. After you process the last appointment, you advance to the action bar described above to process that appointment. Refer to Search for appointment(s), page 6-129.

– **(V)iew appointments** - Lists all appointments and allows you to select the appointment to process next. You then return to the action bar described above to process that appointment. Refer to Search for appointment(s), page 6-129.

  1. Select the (C)ancel action.

If the appointment is an MTF appointment, the system cancels the appointment.

If the appointment is a civilian appointment, you are prompted to indicate whether the place of care has been notified of the cancellation. The system cancels the appointment only if the answer is yes. Only the local CHCS appointment record is canceled, not the appointment in the civilian's own office.

2. In either case, if there is another appointment in the list, you return to the action bar, where you can process the remaining appointments you selected. Refer to Figure 6-75. Cancel/Reschedule Patient Appointments Screen, page 6-129.

3. If there are no more appointments to process, you return to the initial action bar where you can change the search criteria, process additional appointments for the same patient, change the search criteria and cancel or reschedule appointments for another patient, or quit the option and return to the Managed Care Program Menu.

   You can verify that the appointment has been canceled by accessing the Display Patient Appointments (DMCP) option on the Managed Care Program Menu.

   You can also view cancellation data using the End-of-Day Processing option through: Menu Path: PAS System Menu → Clerk Scheduling Menu → EOD

6.4 Health Care Finder Output Products And Reports

6.4.1 Output Products (OHCF)

6.4.1.1 MCP Enrollment Form

Menu Path: PAS System Menu → M → HMCP → OHCF

- **Security Keys**

  CPZ CCP needed by all MCP users. No other security keys required to access this option.

- **Required Fields**

  Patient Name
  Referral ID
  Sponsor Name

Output Device

- **Application Description**

The Output Products option enables you to generate an Enrollment Form, an enrollment Membership ID, or a Patient Label for a specified patient. Refer to Section 6.4.2 Print Patient Address Label (LHCF), page 6-137) This option also allows you to generate a Care Authorization Form or a Provider Label for a specified patient referral.

> **Note:** To access this option, you should be entered as an HCF using the MCP Health Care Finder Profile Enter/Edit (HEAL) option on the Facility File/Table Maintenance Menu. The HCF's record in the system should contain name, telephone number, and the MCP office assigned. This information prints on the CAF.
>
> When a provider is entered as an HCF using the Health Care Finder Profile Enter/Edit option, the following fields from the HCF record print on the CAF: Name, telephone number, and the MCP office to which the provider is assigned.

- **Data Entry Process**

Select the patient

Review Demographics Display

Print the output product

Select the patient

Review Demographics Display

Print the output product

When you finish reviewing the Demographics Display screen, press <Return> to continue. The Generate Appointment Referral Products screen displays. Refer to Figure 6-60. Generate Appointment Referral Products Screen, page 6-102.

1. Enter “E” for (E)nrollment Form at the Generate Appointment Referral Products action bar.

2. Enter device name and confirm right margin of 80.

   If you press <Return> at the *Select DEVICE* prompt, the system returns a message that you can’t print to HOME device, i.e. the screen.

3. When you enter a printer name, the following question displays:

   ```
   Do you want to free up this terminal? No//
   ```

   Press <Return> to accept the “No” default.

   The enrollment form prints to the printer you named. Refer to Figure 6-77. Managed Care Enrollment Form, page 6-136. You return to the Generate Appointment Referral Products action bar where you can print a membership ID card, patient address label, provider label, CAF for the same patient, choose a new patient, or quit. Refer to Section 6.1.3.3 Print Appointment Referral Products, page 6-102.

```
BALBOA NAVY MEDICAL CENTER                                  20 Jan1996@0901
            Personal Data - Privacy Act 1974 (PL 93-579)
                MANAGED CARE PROGRAM ENROLLMENT FORM
_____________________________________________________________________________
__
  ENROLLMENT DATE: 20 Jun 2001  END ELIG/ENROLL DATE: 10 Feb 2003
_____________________________________________________________________________
__
     PATIENT NAME: PICARD,ZACHARY E            FMP/SSN: 20/379-43-6114
 Patient Category: USA ACTIVE DUTY OFFICER         DDS: 20 Sex: MALE
          Address: 862 WEST WYLAND DR          DOB/Age: 19 Feb 1966/35Y
             City: FAIRFAX                Patient SSN: 379-43-6114
            State: VA                      Home Phone: 918-555-0287
         Zip Code: 22030                   Work Phone: 202-555-6801
-----------------------------------------------------------------------------
--
     SPONSOR NAME: PICARD,ZACHARY E            FMP/SSN: 20/379-43-6114
 Patient Category: USA ACTIVE DUTY             DOB/Age: 19 Feb 1966/35Y
          Service: ARMY                           Rank: CPT
     Station Unit: RESOURCE MGMT WASHINGTON Duty Phone: 202-555-6802
     Duty Address: 788 GRANT ST
             City: WASHINGTON                    State: DC
         Zip Code: 20310
_____________________________________________________________________________
__
PRIMARY CARE MANAGER: ESPOSITO,FRANK M        PCM PHONE: 202-271-5850
       Place of Care: FAM PRAC MTF
             Address: 6885 16TH STREET
                City: WASHINGTON                 State: DC
            Zip Code: 20307
_____________________________________________________________________________
__
  INSURANCE COMPANY:                              PHONE:
      POLICY NUMBER:
            Address:
               City:                             State:
           Zip Code:
      Policy Holder:                              SSN:
     Effective Date:                  Expiration Date:
   CASE MANAGEMENT: NO
_____________________________________________________________________________
__
I understand that my enrollment in the Managed Care Program is   contingent
upon my continuing eligibility for health care under the MHSS. I understand the
benefits and patient responsibilities of enrollment in the Managed Care Program
and that enrollment remains in effect until I disenroll. I understand that
enrollment is dependent on CHAMPUS eligibility as shown in DEERS and that
CHAMPUS eligibility ceases upon eligibility for MEDICARE Part A. I further
understand that my failure to follow the rules of this program may result in
either increased cost share or complete non-reimbursement.
-----------------------------------------------------------------------------
--
   SIGNATURE:                                        DATE:
_____________________________________________________________________________
```

```
__
  ADLER,KATHLEEN          30/577-722843   RCD Rm: MAIN FILE ROOM (A)
```

Figure 6-77. Managed Care Enrollment Form

6.4.2 Print Patient Address Label (LHCF)

Menu Path: PAS System Menu → M → HMCP → LHCF

- **Security Keys**

  CPZ CCP needed by all MCP users. No other security keys required to access this option.

- **Required Fields**

  Patient Name
  Output Device

- **Application Description**

The Patient Address Label option permits you to print an address label for one or more patients, provided the patient(s) have complete home or duty addresses.

- **Data Entry Process**

  1. Select the Print Patient Address Label option on the Health Care Finder Menu.
  2. Specify the patient name.
  3. Confirm the patient name.
  4. Enter output device.
  5. Select another patient or exit the option.

- **Report Sample**

Refer to Figure 6-78. Patient Address Label, page 6-138.

```
ZACHARY E PICARD
862 WEST WYLAND DR
FAIRFAX, VA 20030
```

Figure 6-78. Patient Address Label

6.4.3 Health Care Finder Reports Menu (RHCF)

Menu Path: PAS System Menu → M → HMCP → RHCF

Alternate Menu Path: PAS System Menu→ M → OMCP → HRPT

- **Security Keys**

  None

```
   1      Agreement Type Referral Summary
   2      Specialty Type Referral Summary
   3      Provider Network List
   4      PCM Activity Report
   5      Provider Patient Workload Report
   6      Refused Appointments Report

Select Health Care Finder Reports Menu Option:
```

Figure 6-79. Health Care Finder Reports Menu

The Health Care Finder Reports Menu options enable you to generate information on agreement type referrals, specialty type referrals, the provider network, PCM activity, provider patient workload, and refused appointments. Refer to Figure 6-79. Health Care Finder Reports Menu, page 6-138.

6.4.3.1 Agreement Type Referral Summary

Menu Path: PAS System Menu → M → HMCP → RHCF→ 1

Alternate Menu Path: PAS System Menu→ M → OMCP → HRPT→ 1

- **Contents**

This report lists, by division, the number of referrals issued during the user specified report period for each agreement type and specialty. The total number of referrals for each selected division is also printed.

- **Use/Frequency**

This report is run as needed to determine referral activity by specialty.

- **Report Sample**

Refer to Figure 6-80. Agreement Type Referral Summary by Specialty, page 6-139.

```
TIDEWATER                                    06 Jul 1993@1427    Page 1
            REFERRAL SUMMARY FOR AGREEMENT TYPES By SPECIALTY
                     From: 22 May 1993   To: 16 Jul 1993
Division: TRIPLER army MEDICAL CENTER
================================================================================
==
Agreement/   Description                                          Number of
Specialty                                                         Referrals
================================================================================
==
NET        MCP/CIVILIAN NETWORK PROVIDER
----------------------------        Allergy
50
Audiology                                                           25
Cardiology                                                           0
Dermatologist                                                       15
Emergency Medicine                                                  10
Agreement Type Total:                                              100
MTF        MTF HOSPITAL (CIVIL SERVICE)
--------------------------------------        Allergy
15
Cardiologist/Pediatric                                              10
Endocrinologist                                                      0
Agreement Type Total:                                               25

Division Total                                                      125
```

Figure 6-80. Agreement Type Referral Summary by Specialty

6.4.3.2 Specialty Type Referral Summary

Menu Path: PAS System Menu → M → HMCP → RHCF→ 2

Alternate Menu Path: PAS System Menu→ M → OMCP → HRPT→ 2

- **Contents**

This report lists, by division, the number of referrals issued during the user specified report period for each specialty. Subtotals are also printed by each provider supporting the specialty. The total number of referrals for each selected division is also printed.

- **Use/Frequency**

This report is run as needed to determine referral activity for each specialty and by provider.

- **Report Sample**

Refer to Figure 6-81. Specialty Type Referral Summary, page 6-141.

```
A Division                                                  06 Jul 1993~1424 Page
1
                Personal Data - Privacy Act 1974 (PL 93-579)
                     REFERRAL SUMMARY BY SPECIALTY TYPE
                     From: 22 May 1993  To: 16 Jul 1993
Division: AIR FORCE MTF DIVISION
================================================================================
==
Specialty Type/                    Professional                        Number of
 Provider                          Category                            Referrals
======================-
============================================================
CARDIOLOGIST
------------
  CRAWFORD.JACQUI                   PHYSICIAN (OTHER THAN SURGEON)    16
  CRAWFORD,JOSEPH                   PHYSICIAN (OTHER THAN SURGEON)     4
                                              Specialty Type Total:   20
FAMILY PRACTICE PHYSICIAN
-------------------------
  CORBIN. ANTHONY                  PHYSICIAN (OTHER THAN SURGEON)     10
  FLETCHER,THOMAS                  PHYSICIAN (OTHER THAN SURGEON)     15
  MADISON , MICHAEL                PHYSICIAN [OTHER THAN SURGEON)     15
                                              Specialty Type Total:   40
OTORHINOLARYNGOLOGIST
---------------------
  GROVER,GLEN                      PHYSICIAN (OTHER THAN SURGEON)     22

OTORHINOLARYNGOLOGY RESIDENT
----------------------------
  WINTERS,SHARON                    PHYSICIAN (OTHER THAN SURGEON)    19
PEDIATRICIAN
------------
  ALEXANDER, STEPHEN                PHYSICIAN (OTHER THAN SURGEON)    12
  BOWER,KENNETH                     PHYSICIAN (OTHER THAN SURGEON)    18
                                              Specialty Type Total:   30

                                                    Division Total:  131
```

Figure 6-81. Specialty Type Referral Summary

6.4.3.3 Provider Network List

Menu Path: PAS System Menu → M → HMCP → RHCF→ 3

Alternate Menu Path: PAS System Menu→ M → OMCP → HRPT→ 3

- **Contents**

This report summarizes, by type of agreement and specialty, the places of care available for each specialty with the hours of operation and the providers at each place of care. Each provider's PCM capacities (maximum, assigned, and available) are also indicated if the provider is a PCM.

- **Use/Frequency**

This report is run when the site needs to analyze the geographic distribution of the places of care available in the network.

- **Report Sample**

Refer to Figure 6-82. Provider Network List, page 6-143.

```
TRIPLER ARMY MEDICAL CENTER                          31 Aug 1993@1~45   Page 2
                  Personal Data - Privacy Act 1974 (PL-93-579)
                              PROVIDER NETWORK LIST
================================================================================
==
Agreement/                                                    PCM    PCM         PCM
 Specialty   Provider                                  PCM    CAP    ASSIGN      AVAIL
================================================================================
==
CIVILIAN NETWORK PROVIDER
------------------------
  FAMILY PRACTICE PHYSICIAN

        POC Group: R E LARUE
         POC Name: R E LARUE OFFICE
 POC Appt Contact: LORRAINE SMITH
        POC Phone: (804)560-6543
     POC Address: 14557 J CLYDE MORRIS A
                  GLOUCESTER, VA  23061
        POC Hours: MON 0800-1200 1201-1700
                   TUE 0800-1200 1201-1700
                   WED D800-1200 1201-1700
                   THO 0800-1200 1201-1700
                   FRI 0800-1200 1201-1700

             LARUE,R E                               YES    50              50

        POC Group: DEL CARMEN & HARRIS
         POC Name: DEL CARMEN & HARRIS CLINIC
 POC Appt Contact: ALMA JONES
        POC Phone: (804)265-3452
     POC Address: 2245 JEFFERSON AVE
                  NEWPORT NEWS, VA  23601
        POC Hours: MON 0800-1200 1201-1700
                   TUE 0800-1200 1201-1700
                   WED 0800-1200 1201-1700
                   THU 0800-1200 1201-1700
                   FRI 0800-1200 1201-1700
           CRAWFORD,JACQUI                          NO
           DEL CARMEN, GLEN R                      YES      50      3        47
           HARRIS,SCOTT D                          YES      50      0        50
  POC Provider total:  3
```

Figure 6-82. Provider Network List

```
TRIPLER ARMY MEDICAL CENTER                          31 Aug 1993@1~45   Page 2
                  Personal Data - Privacy Act 1974 (PL-93-579)
                            PROVIDER NETWORK LIST
================================================================================
Agreement/                                                        PCM   PCM    PCM
  Specialty   Provider                                      PCM   CAP   ASSIGN AVAIL
 ===============================================================================
CIVILIAN NETWORK PROVIDER (continued)
-------------------------------------
   FAMILY PRACTICE PHYSICIAN  (continued)

        POC Group: FAMILY PRACTICE ASSOCIATES
         POC Name: FAM PRAC ASSOC
 POC Appt Contact: GORGETTA BAIN
        POC Phone: (804)398=765
      POC Address: 4410 MERCURY BLVD
                   NEWPORT NEWS, VA 23601
        POC Hours: MON 0800-1200 1201-1700
                   TUE 0800-1200 1201-1700
                   WED 0800-1200 1201-1700
                   THU 0800-1200 1201-~700
                   FRI 0800-1200 1201-1700

           EAKLE,THOMAS K                                 YES    100
100

           EATON,GARY M                                   YES    100
100

           ELLIS,BARBARA M                                YES    100
100

           EVANS,RICK                                     YES    100
100

   POC Provider total:  4
```

Figure 6-82. Provider Network List (continued)

6.4.3.4 PCM Activity Report

Menu Path: PAS System Menu → M → HMCP → RHCF→ 4

Alternate Menu Paths:

PAS System Menu→ M → OMCP → HRPT→ 4

PAS System Menu→ M → EMCP → OENR → PRPM → 3

- **Contents**

This report can be printed for selected individual PCMs, provider groups, or specialties for a specified date range. The report lists, for the selected providers or specialties, the following information: the provider, group name, PCM maximum capacity, PCM assigned enrollees, and PCM unassigned capacity. The report columns contain totals as follows:

– Number of enrollee primary care visits to the provider

– Number of emergency room visits made by the PCM's enrollees

– Number of referrals made by the PCM for their enrollees

– Number of visits made by the PCM's enrollees to other providers without a referral (includes all scheduled and unscheduled visits made in PAS and MCP for direct and civilian care)

– Number of visits made by the PCM's enrollees to other providers with a referral (includes all scheduled and unscheduled visits made in PAS and MCP for direct and civilian care)

A high-level analysis is presented of how the PCM is performing in the managed care environment. The report indicates possible breaches of agreement by the enrollees who seek care in the emergency room or without a referral. The high-level analysis is also available by specialty and provider group.

- **Use/Frequency**

This report is run monthly to analyze the referral performance of the PCM and the care being sought by the PCM's enrollees.

- **Report Sample**

Refer to Figure 6-83. PCM Activity Report by Provider Group, page 6-146; Figure 6-84. PCM Activity Report by Individual PCM, page 6-147; and Figure 6-85. PCM Activity Report by Specialty, page 6-148.

```
WALTER REED AMC                                          21 Jun 2001@1326  Page
1
                Personal Data - Privacy Act of 1974 (PL 93-579)
               PCM ACTIVITY REPORT By Provider Group
                    FROM: Jun 2001 TO: Jun 2001
                                                    Provider Group: FAM MFD MTF
================================================================================
==                                    ENROLLEE                  ENROLLEE
PCM/              PCM           PCM   #PCM    #ER      #REF  #VISITS    #VISITS
 Agreement        CAP   #ASSIGN AVAIL VISITS  VISITS  MADE   W/REF      W/O REF
================================================================================
==
FAM MED MTF
MTF               500    57     443
Provider Total:   500    57     443

Agreement Total:
 MTF              500    57     443
Grp Grand Total:  500    57     443









* Individual Provider Available Capacity may be LIMITED by the OVERALL Maximum
Patient Capacity of the PROVIDER GROUP and Patients ALREADY assigned to OTHER
PCMs, who may have other Specialties within the PROVIDER GROUP.
```

Figure 6-83. PCM Activity Report by Provider Group

```
WALTER REED AMC                                          21 Jun 2001@1326  Page
1
                Personal Data - Privacy Act of 1974 (PL 93-579)
               PCM ACTIVITY REPORT By Individual PCM
                    FROM: Jun 2001 TO: Jun 2001

================================================================================
==Provider/         Individual          ENROLLEE              ENROLLEE
Group/            PCM            PCM  #PCM    #ER      #REF  #VISITS    #VISITS
 Agreement        CAP   #ASSIGN AVAIL VISITS  VISITS  MADE   W/REF      W/O REF
================================================================================
==
ARIAS,GILBERT
-------------
  INT MED BC
    MTF           500      4    485*
  Group Total:    500      4    485*

ARRIBA,GILBERT
--------------
  ACUTE CR BC
    MTF           500      4    485*
  Group Total:    500      4    485*

ARTURA,GILBERT
  FAM PRAC BC
   MTF            500      4    485*
  Group Total:    500      4    485




* Individual Provider Available Capacity may be LIMITED by the OVERALL Maximum
Patient Capacity of the PROVIDER GROUP and Patients ALREADY assigned to OTHER
PCMs,  who may have other Specialties within the PROVIDER GROUP.
```

Figure 6-84. PCM Activity Report by Individual PCM

```
WALTER REED AMC                                          21 Jun 2001@1326  Page 1
                Personal Data - Privacy Act of 1974 (PL 93-579)
               PCM ACTIVITY REPORT By Specialty
                    FROM: Jun 2001 TO: Jun 2001

================================================================================
==Specialty/                          ENROLLEE                  ENROLLEE
ProviderGroup/      PCM    PCM    #PCM  #ER      #REF       #VISITS   #VISITS
 Agreement          CAP    #ASSIGN AVAIL VISITS  VISITS  MADE   W/REF      W/O
REF
================================================================================
PRIMARY CARE NURSE PRACTITIONER QUALIFIED
----------------------------------------
  POPPETT,DEAN M
    PREV MED MTF
        MTF         500     0    500
    Group Total:    500     0    500

  PRATT,MURIEL
    PREV MED MTF
        MTF         500     10   490
    Group Total:    500     10   490

  PYPER,ALBERTO
    FAM PRAC
        NET         500     0    500
    Group Total:    500     0    500

Specialty Total:   1500    20   1490









* Individual Provider Available Capacity may be LIMITED by the OVERALL Maximum
Patient Capacity of the PROVIDER GROUP and Patients ALREADY assigned to OTHER
PCMs, who may have other Specialties within the PROVIDER GROUP.
```

Figure 6-85. PCM Activity Report by Specialty

6.4.3.5 Provider Patient Workload Report

Menu Path: PAS System Menu → M → HMCP → RHCF→ 5

Alternate Menu Path: PAS System Menu→ M → OMCP → HRPT→ 5

- **Contents**

This report shows the number of outpatient visits being supported and the number of different patients being seen by a provider during the user-specified date range. Subtotals are printed by agreement type as well as by type of provider; e.g., by MTF provider and contractor provider. A grand total of the total visits supported for an agreement type is printed.

- **Use/Frequency**

This report is run as needed to analyze the outpatient care being received through direct care and contractor providers.

- **Report Sample**

Refer to Figure 6-86. Provider Patient Workload Report by Provider Group, page 6-150; and Figure 6-87. Provider Patient Load Report by Provider, page 6-151.

```
TIDEWATER                                                    12 Aug 1993@1648 Page
1
              Personal Data - Privacy Act 1974 (PL-93-579)
                PROVIDER PATIENT LOAD REPORT by Provider Group
                From: 28 Jun 1993    To: 22 Aug 1993
================================================================================
==
Agreement/           Patient Category              Number of  Number of
 Group/Provider      Status                        Visits     Diff Ptns
================================================================================
==
CONTRACT
--------
  CRAWFORD CARDIOLOGY
      CRAWFORD,JACKIE
                 ACTIVE DUTY                        2          2
        HAVERFORD,MICHELLE
                 ACTIVE DUTY                        9          3
                 FAM MBR OF ACTIVE DUTY             7          2
                 RETIRED                           10          2
                 FAM MBR OF RETIRED                 5          1
        Group total:                               33          1.0

   CRAWFORD AND HARRIS
         EDDY,JEANNINE
                 ACTIVE DUTY                        9          2
       Agreement total:                            20          7

     MTF Provider Total:                            5          5*

     Non MTF Provider Total:                       15          5*

     Total Provider Visits:                        20         10*

 * More than one appointment may be linked to a referral. If a referral has an
MTF appointment and a non-MTF appointment linked to it, the patient will be
counted once under the MTF total and once under the non-MTF total.      * A
patient seen by two different providers will be counted once in the totals
under the Number of Different Patients column.
```

Figure 6-86. Provider Patient Workload Report by Provider Group

```
TIDEWATER                                          12 Aug 1993@1649  Page 1
                 Personal Data - Privacy Act 1974 (PL-93-S79)
                   PROVIDER PATIENT LOAD REPORT by Provider
                    From: 28 Jun 1993    To: 22 Aug 1993
================================================================================
==
Agreement/      Patient Category                     Number of  Number of
 Provider/Group Status                               Visits     Diff Ptns
================================================================================
==
CONTRACT
--------
  CRAWFORD,JACKIE
    CRAWFORD CARDIOLOGY
              ACTIVE DUTY                             15           2
              FAM MBR OF ACTIVE DUTY                   5           4
              RETIRED                                 10           2
              FAM MBR OF RETIRED                      17           7
  Agreement total:                                    47          15

 MTF STAFF
----------
  ALEXANDER,STEPHEN
     PEDIATRICS LAFB
              ACTIVE DUTY                              1           1

  Agreement total:                                     1           1

SUPPLEMENTAL CARE/DIAGNOSTIC SERVICES
--------------------~~---------------
   THOMAS,LARRY
     WATSON MEDICINE GROUP
              ACTIVE DUTY                              4           1
              FAM MBR OF ACTIVE DUTY                   1           1

    Group total:                                       5           2

  Agreement total:                                     5           2

 MTF Provider Total:                                  10           6*

 Non MTF Provider Total:                              43          15*

 Total Provider Visits:                               53          21*

* More than one appointment may be linked to a referral. If a referral has an
MTF appointment and a non-MTF appointment linked to it. the patient will be
counted once under the MTF total and once under the non-MTF total. A patient
seen by two different providers will be counted once in the totals under the
Number of Different Patients column.
```

Figure 6-87. Provider Patient Load Report by Provider

6.4.3.6 Refused Appointments Report

Menu Path: PAS System Menu → M → HMCP → RHCF→ 6

Alternate Menu Path: PAS System Menu→ M → OMCP → HRPT→ 6

- **Contents**

This report lists, by type of appointment refusal (MTF declined, Network declined, and Non-network declined), the patients who have refused an appointment during the user-specified report period. The user may select specific patients.

- **Use/Frequency**

This report is run when there is a need to assess the frequency of appointment refusals or to determine whether a patient is truly unable to obtain an appointment when a patient complaint is filed.

- **Report Sample**

Refer to Figure 6-88. Refused Appointments Report, page 6-153.

```
A Division                                              06 Jul 1996@1437   Page 2
                        Personal Data - Privacy Act 1974 (PL 93-579)
                       REFUSED APPOINTMENTS REPORT for ALL PATIENTS
                          From: 22 May 1993      To: 16 Jul 1993
================================================================================
==
Refused Status/          FMP/SSN   DDS      Patient Category Pat Home Ph'  Specialty
# Patient Name            HCF                Referral#         Refusal Time
Location Refusal Reason
================================================================================
==
NON-MTF DECLINED (continued)
---------------------------
CRAWFORD,MINDY (Cont.)   20/354-27-7242      USN ACTIVE DUTY
CRAWFORD,JACQUI 930000104                                      30Jun93Q0959
UNHAPPY WITH GROUP/PROVIDER
FREE TEXT NON-MTF
```

Figure 6-88. Refused Appointments Report

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intentionally.

Section 7 Interactive Non-Availability Statement (NAS)/Care Authorization Processing

7. INTERACTIVE NON-AVAILABILITY STATEMENT (NAS)/CARE AUTHORIZATION PROCESSING

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7.1 Interactive NAS Processing Menu (IMCP)

Introduction

Medical treatment facilities (MTFs) issue non-availability statements (NASs) to authorize using Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) funds to pay for inpatient care that cannot be provided by the MTF. Outpatient NASs are no longer required. NASs are issued for CHAMPUS eligible patients only and are filed; i.e. recorded, on the Defense Enrollment Eligibility Reporting System (DEERS). NASs are not stored in CHCS.

The Non-Availability Statement Processing (NNAS) option on the Interactive NAS Processing Menu (IMCP) is used to issue a new NAS, cancel or print an NAS, or view a patient's NAS history data filed on DEERS. The NAS Processing Menu is described as

interactive, because NAS processing cannot be batch processed. NAS processing can only be accomplished in real time with DEERS online.

The DEERS database summarizes the NAS data every month. After the data has been summarized by DEERS, CHCS users can request the following summary reports through the Reports for NAS Menu (RNAS):

- Branch of Service Summary Report
- NAS Statistical Report
- Reason for Issue by Patient Category Report
- Reason for Issue Summary Report.

7.1.1 Non-Availability Statement Processing (NNAS)

Menu Path: PAS System Menu → M → IMCP → NNAS

- **Security Keys**

  CPZ CCP
  CPZ NAS
  CPZ OHI

- **Required Fields**

  Patient name or NAS number
  Issue type
  Issue reason
  DMIS ID
  Issuing officer
  Major diagnostic category (MDC)**
  Admitting facility*
  Admission date*
  NAS status
  Issuing type
  Medically inappropriate code
  Treatment facility**
  Treatment facility city**
  Treatment facility state**
  Treatment facility ZIP**

Mileage**
Output device

* Only required if issue type is retroactive.
** Only required if issue reason is medically inappropriate.

- **Application Description**

This option allows you to issue, print, or cancel NASs in DEERS. Canceled NASs are not deleted from DEERS, but remain available within the system to be queried and printed. NASs are available to be accessed either by NAS number or by patient name. This option functions only when DEERS is online.

- **Business Rules**

– NASs are filed only for CHAMPUS eligible beneficiaries.

> **Note:** The NNAS option does not allow you to issue an NAS for an active duty patient.

– A beneficiary must be registered on DEERS and an NAS must be filed on DEERS before claims can be paid.

- **Data Entry Process**

7.1.1.1 Print or Cancel an Individual NAS

Access the NNAS option

Select the NAS number
or
Select the patient name

Query DEERS for NAS

Print the NAS

Cancel the NAS

Quit and return to the initial action bar

Access the NNAS option

```
  NNAS   Non-Availability Statement Processing
  RNAS   Reports for NAS

Select Interactive NAS Processing Menu Option: NNAS
```

Figure 7-1. Interactive NAS Processing Menu

The system prompts you to begin by displaying the initial action bar. You can access an individual NAS by number, select a patient to print or cancel their NASs, or quit and exit the option.

Select the NAS number

Refer to Figure 7-2. NAS Processing Initial Action Bar and First Prompt When Selecting by NAS Number, page 7-4.

```
NAS PROCESSING

Select (N)AS Number, (P)atient Name, (Q)uit: P//N
Select NAS NUMBER: 00373207001
```

Figure 7-2. NAS Processing Initial Action Bar and First Prompt When Selecting by NAS Number

1. Enter “N” at the initial action bar.

2. The system prompts you to enter an NAS number.

   Enter the NAS number at the *Select NAS NUMBER* prompt.

The NAS number is an 11-digit identifier (e.g., 0702 6320 200) composed of the following elements:

Positions 1-4	=	DMIS ID
Position 5	=	Year of the claim
Positions 6-8	=	Julian date of NAS issuance
Positions 9-11	=	NAS serial number:
0001 - 669	=	regular NAS condition
1700 - 799	=	chronic/retroactive
2800 - 899	=	chronic
900 - 999	=	retroactive

Note: Sites may issue only 99 retroactive NASs per day.

Refer to Figure 7-16. NAS Display Screen, page 7-23, for an example of an NAS number on a Non-Availability Statement.

Select the patient name

Refer to Figure 7-3. NAS Processing Initial Action Bar and First Prompt When Selecting by Patient Name, page 7-5.

```
NAS PROCESSING


Select (N)AS Number, (P)atient Name, (Q)uit: P//

Select PATIENT NAME: parrot,wendy
                                        30/101-10-0035 02 Feb 1953 F
         OK? YES//   (YES)
SPONSOR NAME: PARROT,VINCENT//
```

Figure 7-3. NAS Processing Initial Action Bar and First Prompt When Selecting by Patient Name

Query DEERS for NAS

The system queries DEERS and performs a CHCS/DEERS Discrepancy Data Check and a DEERS Check. Refer to Figure 7-4. Processing DEERS Request Message, page 7-6, Section 4, DEERS Functions and Processes.

```
CHCS-DEERS                  Processing DEERS Request


Waiting To Process.
Processing Request..


     Press 'Q' to quit and not process this DEERS request.
```

Figure 7-4. Processing DEERS Request Message

If the NAS is not in DEERS, the system displays an error message and returns to the initial action bar. Refer to Figure 7-5. DEERS NAS Response Error Message, page 7-6. The number, 86, is the error code that corresponds to the text, "NAS Record Not Found."

```
      Personal Data - Privacy Act of 1974 (PL 93-579)

DEERS NAS RESPONSE       DATA RETURNED FROM DEERS     21 Jun 2001@1242

   NAS Response: 86 NAS Record Not Found


Press <RETURN> to continue
```

Figure 7-5. DEERS NAS Response Error Message

If the NAS is found in DEERS, the system displays the NAS data and an action bar permitting you either to print the NAS or to cancel the NAS (if it is still active). Refer to Figure 7-6. NAS Display Screen, page 7-7. Refer to Appendix A, DEERS Eligibility Override Code Picklist, for a list of discrepancies that will keep you from receiving a completed NAS display screen. Also listed are the related areas and screens where the discrepancies may be corrected.

```
                                NAS DISPLAY
          Patient: Parrot,Wendy                        FMP/SSN: 30/101-10-0035
Patient Category: A41                                     DDS: 30
         DOB/AGE: 02 Feb 1953/48Y                         Sex: FEMALE
             ACV: C-CHAMPUS/DIRECT CARE ELIGIBLE
_____________________________________________________________________________
        NAS Number: 00373207001                  Issue Date: 21 Jun 2001
            Status: UNCONDITIONAL
      Issue Reason: 3 - MEDICALLY INAPPROPRIATE
               MDC: 65 ARTHROSCOPY
          Facility:                          Admission Date:
   Other Insurance: N                         Policy Number:
 Insurance Company:
   Issuing Officer: JOHNSON,RICHARD
         Remarks 1:
                  2:
                                3:
   Medically Inapp Code: Other                      Mileage: 999
               Facility:Palomar/Pomerado Hospital
                   City:San Marcos                  State:CA    ZIP:92069
_____________________________________________________________________________
Select (P)rint, (C)ancel, or (Q)uit: P//
```

Figure 7-6. NAS Display Screen

Print the NAS

1. Press <Return> to accept the (P)rint action on the NAS Display screen.

   The system displays the *OK TO PRINT? Yes//* prompt.

2. If you enter "N," for NO, the system returns you to the NAS Display action bar.

3. If you press <Return> to accept the Yes default, the system prompts you to select the output device and confirm the right margin.

> **Note:** If the patient is not yet registered in CHCS, the system prompts you at this time to register the patient using the Mini Registration option. You cannot print the NAS until the patient is registered in CHCS. Refer to Figure 7-7. Sample Mini Registration Screen, page 7-8. Refer to explanation following Figure 5-9. Mini Registration Screen, for details.

```
Patient: PEARL,ZACHARY N.                                        Mini
Registration
FMP/SSN: 20/569-69-4415       DOB: 12Jun75       PATCAT: N11    Sex: M
                 Personal Data - Privacy Act of 1974 (PL 93-579)
      Patient: PEARL,ZACHARY N.                        DOB: 12 Jun 1975
       PATCAT: N11 (USN ACTIVE DUTY)                   FMP: 20
   Home Phone: 974-2333        W:                      SSN: 569-69-4415
 Patient Addr: 1020 NEWPORT DRIVE                      Sex: MALE
         City: HAMPTON               St/Cntry: VA      Zip: 23665

      Sponsor: PEARL,ZACHARY N.                  Service: NAVY
          FMP: 20                          Sponsor SSN: 569-69-4415
       PATCAT: N11 (USN ACTIVE DUTY)                   DOB: 12 Jun 1975
  Command Sec:                                        Rank:
 Station/Unit:
 Duty Address:
         City:                        St/Cntry:        Zip:
   Duty Phone:                                        DSN:

  O/P Rec Loc:
  O/S Rec Loc:
  Primary Phy:
  Reg Comment:

 Help = HELP      Exit = F10     File/Exit = DO                    INSERT OFF
```

Figure 7-7. Sample Mini Registration Screen

When the data is sent to the printer, the system returns you to the NAS Display action bar for the current NAS. You can print the NAS again, cancel it (if it has not been canceled), or quit processing the current NAS and return to the initial action bar.

Cancel the NAS

1. Enter “C” at the NAS Display screen action bar.

   The system prompts you to confirm the cancellation.

2. If you confirm the cancellation, the system sends a transaction to DEERS to cancel the NAS.

3. If you elect to quit without canceling, the system returns you to the *Select PATIENT NAME* prompt. At this prompt, you can press <Return> and then enter “Q” to quit and return to the Interactive NAS Processing Menu.

Quit and return to the initial action bar

7.1.1.2 Issuing an NAS

- **Business Rules**

– If the patient category or date of birth (DOB) is missing from the registration data for this patient when you select the Quit action, the system displays a message informing you of this missing information. Select either the Full Registration or Mini Registration actions to enter the missing information.

– If the patient belongs to a patient category that is not CHAMPUS eligible (that is, a patient category implying active duty or reserve status, or beginning with the letters K or X), the system displays the following alert message on the Demographics Display screen just above the action bar: *Patient Category makes this Patient ineligible for NAS Issuance*

– When the patient category makes the patient ineligible for NAS Issuance, the Demographics Display action bar permits you only to enter/edit the patient registration using the Full Registration or Mini Registration options, or to quit the screen and return to the initial action bar to select another patient or NAS.

– There is no default on the Demographics Display action bar. You must enter the letter enclosed in parentheses to make your choice; i.e., enter “C” to continue.

– If the patient is DEERS ineligible or not found in DEERS (or if the patient’s sponsor is in DEERS and you enter a DEERS eligibility override code because the patient is clearly DEERS eligible), the Demographics Display action bar permits you to enter/edit the patient registration using the Full Registration or Mini Registration options, to enter/edit other health insurance (OHI) using this functionality, or to perform a Repeated DEERS check. The action bar also permits you to quit the screen and return to the initial action bar, to select another patient, or to continue and process NASs for the current patient.

– The action bar on the NAS History screen permits you to issue a new NAS, to print an existing NAS, or to cancel an active NAS when the patient has previously issued NASs. If the patient has no previously issued NASs, the action bar allows you to either issue an NAS or quit.

– In the lower portion of the NAS Issue screen, the NAS Number is blank at this point. DEERS issues the NAS number after you file the data entered through the NAS Issue screen. Issue date is always today, and the status defaults to the patient’s status on DEERS.

– Unconditional status means the patient is on DEERS and is CHAMPUS eligible. Conditional status means that the patient is not found on DEERS.

– If a patient is not found on DEERS, validate that you have entered the correct social security number (SSN) and DOB. You cannot enter or edit data in the NAS Number, Issue Date, or Status fields from this screen.

– Once an NAS is filed, you can never change it. To correct the NAS you must cancel the NAS and reissue it with a new NAS number.

- **Data Entry Process**

Access the NNAS option

Select the patient name

Review the Current DEERS Eligibility screen

Review the Demographics Display

View NAS history

Select the (I)ssue action

Enter NAS issue data

Enter medically inappropriate data

Review the NAS Display screen

Print the NAS

Access the NNAS option

Select patient

The system prompts you to begin by displaying the initial action bar prompting you either to process an individual NAS (by number), select the patient who will be issued NAS(s), or quit and exit the option.

```
NAS PROCESSING


Select (N)AS Number, (P)atient Name, (Q)uit: P//<Return>

Select PATIENT NAME: P0035
     1   P0035  PARROT,VINCENT         20/101-10-0035 09 Feb 1960 M FO5
     2   P0035  PARROT,WENDY           30/101-10-0035 02 Feb 1953 F
     3   P0035  PARROT,BRIAN           01/101-10-0035 20 May 1976 M
     4   P0035  PRESCOTT,LOWELL L      20/100-24-0035 01 Sep 1953 M NE7
Choose 1-4: 2  PARROT,WENDY
SPONSOR NAME: PARROT,VINCENT//<Return>
```

Figure 7-8. Non-Availability Statement Processing Initial Action Bar and Patient Selection Prompts

1. Press <Return> to accept the default (P)atient Name action.

2. Enter patient ID.

   The system prompts you to enter a patient name, however, you should follow your site's accepted method of entering patient ID. When you enter the first letter of the patient's last name and the last four digits of the sponsor's SSN, the system displays a picklist (refer to Figure 7-8. Non-Availability Statement Processing Initial Action Bar and Patient Selection Prompts, page 7-11) of all registered patients with that letter and number combination.

   Select the patient whose family member prefix (FMP), sponsor SSN, and patient DOB match the patient who needs the NAS.

If the patient is not yet registered in CHCS, the system prompts you to register the patient using the Mini Registration option. Refer to Figure 7-7. Sample Mini Registration Screen, page 7-8, and the explanation following Figure 5-9. Mini Registration Screen, for details on Mini Registration.

> **Note:** If the SSN and DOB are correct and the patient is still not found on DEERS, direct the patient to the MTF administration office to register on DEERS. Claims are not paid until the patient is registered on DEERS. If the patient is clearly CHAMPUS eligible and urgently needs care not available at the MTF, but is not yet registered on DEERS (a newborn, for example), the patient can be provided the necessary care prior to registration. In this case, a conditional NAS is issued in CHCS. As soon as the patient is registered in DEERS, the claim can be processed.

3. Verify the sponsor.

   Press <Return> to verify that the sponsor name is correct.

Review the Current DEERS Eligibility screen

After you verify the sponsor, the system queries DEERS (refer to Figure 7-4. Processing DEERS Request Message, page 7-6) and performs a CHCS/DEERS Discrepant Data Check and a DEERS Check. Refer to Section 4 DEERS Functions and Processes; Figure 4-13. CHCS/DEERS Discrepancy Data Screen; and Figure 4-14. CHCS/DEERS Discrepancy Data Continued.

If a DEERS eligibility check has been performed within the last five days, the system displays the Current DEERS Eligibility screen. If a DEERS eligibility check has not been performed within the last five days, a DEERS eligibility check is performed automatically and the DEERS Eligibility Data screen displays showing actual patient status today on DEERS. The DEERS Eligibility Data screen is not the same data displayed on the Current Eligibility screen which displays data from information stored in CHCS up to five days ago, not directly from DEERS. Refer to Figure 7-9. Current DEERS Eligibility Screen, page 7-13.

```
                          CURRENT DEERS ELIGIBILITY
             Name: PARROT,WENDY              FMP/SSN: 30/101-10-0035
  Patient Category: USA FAM MBR AD               DDS: 30
          DOB/Age: 02 Feb 1953/48Y               Sex: FEMALE
_____________________________________________________________________________
            Sponsor Rank: CAPTAIN
             Sponsor UIC: S31LFJSQ-0459 OPERATIONS GP
                 DMIS ID: 0037-WALTER REED AMC
                     ACV: C-CHAMPUS/DIRECT CARE ELIGIBLE
          ACV Start Date: 11 Mar 1999    Region Code: 02
  Care Authorization PH#: 555-2349      PCM Location: DIRECT CARE PC
            Direct Care: ELIGIBLE          Medicare: NOT ELIGIBLE
Dir Care Elig Start Date: 12 Mar 2001       CHAMPUS: ELIGIBLE
  Dir Care Elig End Date: 10 Feb 2003
  Eligibility End Reason:

                           BRAC Pharmacy Eligibility: NO
          Override Code:
        Date of Request: 17 Jun 2001
_____________________________________________________________________________
Select to (V)iew more DEERS data,(P)rint,(R)epeat DEERS check, (C)ontinue,
       or (Q)uit: C//
```

Figure 7-9. Current DEERS Eligibility Screen

Actions on the Current DEERS Eligibility action bar are as follows:

- **(V)iew more DEERS** - Displays a second screen containing the remainder of the DEERS data for the selected patient. Refer to Figure 5-5. Current DEERS Eligibility, Second Screen, page 20.

- **(P)rint** - Prints a copy of both Current DEERS Eligibility screens.

- **(R)epeat DEERS check** - Invokes a new online DEERS check for the selected patient. DEERS must be online to perform this action. This action is displayed only for a new enrollment, not for an existing enrollment.

- **(C)ontinue** - Displays the Demographics Display screen. Refer to Figure 7-10. Demographics Display Screen, page 7-14. This is the default action.

- **(Q)uit** - Exit the option without further processing.

Review the Demographics Display

When you press <Return> to accept the default (C)ontinue action at the Current DEERS Eligibility screen action bar or DEERS Eligibility Data screen action bar, the system displays

the Demographics Display screen. Refer to Figure 7-10. Demographics Display Screen, page 7-14.

```
                              DEMOGRAPHICS DISPLAY
                  Name: PARROT,WENDY            FMP/SSN: 30/101-10-0035
      Patient Category: USA FAM MBR AD              DDS: 30
          Patient Type:                             Sex: FEMALE
              MCP Status:                              DOB/Age: 02 Feb
1953/48Y
                  ACV: C-CHAMPUS/DIRECT CARE EL  DMIS ID:
           Direct Care: ELIGIBLE               Medicare:
_____________________________________________________________________
          Sponsor Name: PARROT,VINCENT             Rank: CAPTAIN
          Station/Unit: 0459 OPERATIONS     GP      DSN:
          Home Address: 867 GIBSON BLVD
                  City: FAIRFAX                  State: VIRGINIA
              ZIP Code: 22030                Home Phone: 918-555-2227
            Duty Phone: 202-555-1117         Work Phone:
  Registration Comment:
Last Registration Date: 20 Feb 2001@1030
Outpatient Record Room:
       MCP Enroll Date:                  End Enroll Date:
  Primary Care Manager:                       PCM Phone:
           Primary OHI: NOT ASSIGNED          Case Mgmt:
_____________________________________________________________________
Select (F)ull, (M)ini, (O)HI, (N)ew Patient, (R)epeat DEERS, (C)ontinue,
       or (Q)uit DEMOGRAPHICS:
```

Figure 7-10. Demographics Display Screen

The Demographics Display screen has a three-window format.

The Display Window features patient demographics.

The Select Window displays the sponsor's name, station/unit, rank, and DSN number. The remaining data in the Select window pertains to the patient. This data is display only.

The Interact Window displays an action bar with the following actions:

- **(F)ull = Full Registration** - Displays the Full Registration screens and allows you to edit the patient's registration. Upon completion, the system returns to the Demographics Display action bar.
- **(M)ini = Mini Registration** - Displays the Mini Registration screens and allows you to edit the appropriate fields (e.g., home address, home phone). Upon completion, the system returns to the Demographics Display action bar.

- **(O)HI = Other Health Insurance** - Allows you to enter/edit/view the patient's other health insurance information. Upon completion, the system returns to the Demographics Display action bar.

- **(N)ew Patient** - Returns you to the *Select PATIENT*: prompt where you can select a different patient for processing. Processing of the initially selected patient terminates when the you select this action.

- **(C)ontinue** - Displays the NAS History screen.

- **(Q)uit Demographics** - Returns you to the NAS Processing action bar. Refer to Figure 7-3. NAS Processing Initial Action Bar and First Prompt When Selecting by Patient Name, page 7-5. The following edits are performed before issuing the NAS.

  1. If the patient category or DOB is missing from the registration data for this patient, the system displays a message informing you of this missing information. Select either Full or Mini Registration to enter the missing information.

  2. If the patient belongs to a patient category that is not CHAMPUS eligible (that is, a patient category implying active-duty or reserve status, or beginning with the letters K or X), the system displays the following alert message on the Demographics Display screen: *Patient Category makes this Patient ineligible for NAS Issuance*

  3. When the patient category makes the patient ineligible for NAS Issuance, the Demographics Display action bar only permits you to enter/edit the patient registration (using the Full Registration or Mini Registration option), or quit the screen and return to the initial action bar.

  4. There is no default on the Demographics Display action bar. You must enter the letter enclosed in parentheses to make your choice; e.g., enter "C" to continue.

  5. If the patient is DEERS ineligible or not found in DEERS (or if the patient's sponsor is in DEERS and you enter a DEERS Eligibility Override Code because the patient is clearly DEERS eligible), the Demographics Display action bar permits you to enter/edit the patient registration (using the Full Registration or Mini Registration option), to enter/edit OHI, or to repeat the DEERS check. The action bar also permits you to quit the screen and return to the initial action bar, to select another patient, or to continue and process NASs for the current patient.

View NAS History

Select the (C)ontinue action on the Demographics Display action bar.

The system displays the NAS History screen, listing all active and canceled NASs for the selected patient. Refer to Figure 7-11. NAS History Screen, page 7-16.

If the patient has four or fewer NASs in DEERS, the system obtains complete information on all NASs during the initial DEERS check.

If the patient has more than four NASs in DEERS, the system obtains only summary information on the NASs during the initial DEERS check; complete information on any given NAS can be obtained from DEERS only if a specific NAS is selected to process.

```
                              NAS HISTORY
                 Patient: PARROT,WENDY        FMP/SSN: 30/101-10-0035
         Patient Category: A41                    DDS: 30
                  DOB/AGE: 02 Feb 1953/48Y       Sex: FEMALE
                      ACV: CHAMPUS/DIRECT CARE ELIGIBLE
-------------------------------------------------------------------
           NAS Number   Status  MDC  Reason for Issue




--------------No previously issued NAS for this  patient------------
      Select (I)ssue, or (Q)uit: I//
```

Figure 7-11. NAS History Screen

The NAS History screen action bar contains the following actions:

- **(I)ssue** - Allows you to issue a new NAS.
- **(Print)** - Prints an existing NAS. This action does not display if the patient has no previously-issued NASs.
- **(C)ancel** - Cancels a previously-issued, active NAS. This action does not display if the patient has no previously-issued NASs.
- **(Q)uit** - Exits the NAS History screen.

Select the (I)ssue action

Select the (I)ssue action to enter a new NAS.

The system displays the NAS Issue screen. Refer to Figure 7-12. NAS Issue Screen, page 7-18.

The upper portion of the NAS Issue screen displays patient name, FMP/SSN, Patient Category, DEERS dependent suffix (DDS), Sex, DOB/Age, and alternate care value (ACV). The ACV indicates the patient's DEERS eligibility and enrollment plan. You cannot edit any of these fields.

1. In the lower portion of the NAS Issue screen, the NAS Number is blank at this point. DEERS issues the NAS number after you file the data entered through the NAS Issue screen. Issue date is always today, and the status defaults to the patient's status on DEERS.

2. Unconditional status means the patient is on DEERS and is CHAMPUS eligible. Conditional status means that the patient is not found on DEERS.

3. If a patient is not found on DEERS, validate that you have entered the correct SSN and DOB. You cannot enter or edit data in the NAS Number, Issue Date, or Status fields from this screen.

> **Note:** If the SSN and DOB are correct and the patient is still not found on DEERS, direct the patient to the MTF administration office to register on DEERS. Claims are not paid until the patient is registered on DEERS. If the patient is clearly CHAMPUS eligible and urgently needs care not available at the MTF, but is not yet registered on DEERS (a newborn, for example), the patient can be provided the necessary care prior to registration. In this case, a conditional NAS is issued. As soon as the patient is registered in DEERS, the claim can be processed.

Enter NAS issue data

Fields on the NAS Issue screen prompts you to enter all data required to issue a conditional or unconditional NAS, which is retroactive, chronic, non-chronic or combinations of the above.

```
             NAS DATA: PARROT,WENDY                                  NAS ISSUE

                          Patient: PARROT,WENDY        FMP/SSN: 30/101-10-0035
                 Patient Category: USA FAM MBR AD          DDS: 30
                              Sex: FEMALE              DOB/Age: 02 Feb 1953/48
                              ACV: CHAMPUS/DIRECT CARE
================================================================================
                        NAS Number:                  Issue Date: 21 Jun 2001
                        Issue Type:                      Status: UNCONDITIONAL
                      Issue Reason:                    DMIS ID:
                               MDC:
                 Admitting Facility:
                     Admission Date:

                   Other Insurance: Yes, CHAMPUS Supplemental
                  Insurance Company: BLUE CROSS/BLUE SHIELD, NC
                      Policy Number: 6782

                   Issuing Officer:
                         Remarks 1:
                                 2:
                                 3:

    Ask for Help = HELP     Screen Exit = F10     File/Exit = DO  INSERT OFF
```

Figure 7-12. NAS Issue Screen

1. Issue Type

   There are four issue types:

R	Retroactive/Chronic (valid for one year in the past)
Y	Retroactive/Nonchronic (valid for 30 days or less in the past)
C	Nonretroactive/Chronic (valid for one year in the future)
N	Nonretroactive/NonChronic (valid for 30 days or less in the future).

   If care does not occur within the valid period indicated above, the NAS must be canceled and a new NAS issued before the care is authorized.

2. Issue Reason

   Issue reason is the reason why the MTF cannot provide the care inside the facility. Choices are as follows:

   Non-Enrolled Patients

   3 Medically inappropriate (Example: The patient becomes ill where no government MTF is nearby and travel to the nearest MTF is impractical.)

   4 Facility temporarily not available (Example: The MTF is doing a light system upgrade and all the operating rooms are closed.)

   5 Professional capability temporarily not available (Example: The patient requires an orthopedic surgeon and the only MTF orthopedic surgeon is on TDY for a month.)

   6 Facility or professional capability permanently not available (Example: The patient requires an orthopedic surgeon and the MTF does not have an orthopedic surgeon or facilities for doing orthopedic surgery.)

   Enrolled Patients

   7 Care authorization inside network (Example: CHAMPUS-eligible and enrolled in MCP.)

   8 Care authorization outside network (Example: CHAMPUS-eligible and enrolled in MCP.)

   Obsolete

   9 Non-enrollee (Authorizes CHAMPUS-eligible patients not enrolled in MCP to see a network provider. Not currently used and is against policy.)

3. DMIS ID

   Enter the Defense Medical Information Systems Identification (DMIS ID) of the issuing MTF. This can be any valid DMIS ID, provided your site reports workload for this DMIS ID. DEERS must recognize this as a valid DMIS ID. If DEERS does not recognize the DMIS ID, contact the DEERS office and resolve the discrepancy.

4. MDC

   The medical diagnostic code (MDC) describes, in broad terms, the type of medical care the patient requires. Enter a double question mark (??) to see a list of choices. Refer to Appendix A, Major Diagnostic Codes (MDC), for a list of these codes.

5. Admitting Facility and Admission Date

   The name of the admitting facility and the admission date are only required when the issue type is retroactive/chronic or retroactive/nonchronic. The admission date must be a past date. The admission date could be the date of care given; i.e., a patient does not have to be admitted.

6. Other Insurance, Insurance Company, and Policy Number

   The primary policy information defaults into the Other Insurance, Insurance Company, and Policy Number fields if the patient has OHI entered in CHCS. If the patient has OHI entered in CHCS, one of these codes displays in the Other Insurance field:

S	CHAMPUS Supplement
C	CHAMPUS/CHAMPVA
CO	Commercial
GR	Employer Group
MS	MEDICARE
SD	Student

7. Issuing officer

   Enter a double question mark (??) to view a list of site definable choices.

> **Note:** The issuing officer must be entered into the NAS Issuing Officer file using the NAS Issuing Officer Enter/Edit (ISSO) option on the Facility File/Table Maintenance Menu. Refer to Section 2.1.2.7 NAS Issuing Officer Enter/Edit (ISSO). Users must be assigned security keys CPZ CCP and CPZ FILE in order to access the Facility File/Table Maintenance Menu.

8. Remarks

   Enter up to three lines at 30 characters per line in the Remarks field to further explain the reason for the NAS.

Enter medically inappropriate data

If the issue reason is "medically inappropriate," the system requires you to complete a second screen to enter a medically inappropriate code, treatment facility name, facility location (i.e., ZIP code, city, and state), and mileage. Refer to Figure 7-13. NAS Issue Second Input Screen, page 7-21.

```
NAS DATA: PARROT,WENDY                                                    NAS
ISSUE

          Patient: PARROT,WENDY                          FMP/SSN: 30/101-10-
0035
Patient Category: USA FAM MBR AD                             DDS: 30
              Sex: FEMALE                                DOB/Age: 02 Feb
1953/48
              ACV: CHAMPUS/DIRECT CARE
================================================================================
=
 Medically Inappropriate Code:
           Treatment Facility:
                     ZIP Code:
                         City:
                        State:
                      Mileage:
________________________________________________________________________________
_
File/exit    Abort    Edit
File changes and exit.
```

Figure 7-13. NAS Issue Second Input Screen

1. Medically Inappropriate Code

   Choices for medically inappropriate code are:

   - Other
   - PCS (between permanent duty assignments)
   - TDY (Temporarily away from permanent residence)
   - TRV (Travel difficult or costly).

2. Treatment Facility

   Enter the name of the facility where treatment was rendered.

3. ZIP code

   As soon as you enter the ZIP code, the city and state will be entered for you and the system displays the following prompt:

   Are Treatment Facility City and State correct? Yes//

   If you enter "N," to indicate the city and/or state are not correct, the cursor returns to the city field and you can manually enter the city and state.

4. Mileage

   Enter the number of miles from where the patient received care to the closest MTF.

5. File the data

When the second NAS Issue screen is complete, you can file the data, abort without filing, or edit the NAS. Refer to Figure 7-13. NAS Issue Second Input Screen, page 7-21. If you want to review the NAS prior to filing, select the Edit action. Once an NAS is filed, you can never change it. To correct the NAS you must cancel the NAS and reissue it with a new NAS number.

When you file the data, the system processes the NAS. If the process is successfully completed, DEERS sends a successful completion message. Refer to Figure 7-14. Transaction Complete Message, page 7-22.

```
                Personal Data - Privacy Act of 1974 (PL 93-579)

DEERS NAS RESPONSE        DATA RETURNED FROM DEERS     21 Jun 2001@1257

NAS Response:  99  Transaction Complete

Press <RETURN> to continue
```

Figure 7-14. Transaction Complete Message

If there are discrepancies between the data you entered and the data on DEERS, you receive a DEERS data discrepancy message. Refer to Figure 7-15. DEERS Data Discrepancy Message, page 7-23.

```
              Personal Data - Privacy Act of 1974 (PL 93-579)

DEERS NAS RESPONSE       DATA RETURNED FROM DEERS     21 Jun 2001@1257

NAS Response:  60  Invalid DMIS ID number.

This discrepancy can be corrected on the NAS ISSUE SCREEN.

Press <RETURN> to continue
```

Figure 7-15. DEERS Data Discrepancy Message

Review the NAS Display screen

Press <Return> at the transaction complete message. The processing continues and the NAS Display screen displays. Refer to Figure 7-16. NAS Display Screen, page 7-23.

Print the NAS

```
                                    NAS DISPLAY
          Patient: PARROT,WENDY                       FMP/SSN: 30/101-10-0035
   Patient Category: A41                                  DDS: 30
        DOB/AGE: 02 Feb 1953/48Y                          Sex: FEMALE
           ACV: CHAMPUS/DIRECT CARE ELIGIBLE
_____________________________________________________________________________
  NAS Number: 00373207700                              Issue Date: 21 Jun 1996
      Status: UNCONDITIONAL
Issue Reason: 3 - Medically inappropriate
          MDC: 02  DISEASES AND DISORDERS OF THE EYE
     Facility: Palomar/Pomerado                 Admission Date: 22 May 1996
 Other Insurance:  S                              Policy Number: 6702
    Insurance Company: BLUE CROSS/BLUE SHIELD, NC
      Issuing Officer: SMITH,JAMES A
        Remarks 1:
                 2:
                 3:
Medically Inapp Code: Temporarily away from per       Mileage: 150
            Facility: Palomar/Pomorado
              City: San Marcos                       State: CA   ZIP: 92069
_____________________________________________________________________________
OK TO PRINT? Yes//
```

Figure 7-16. NAS Display Screen

1. When you accept the default to print the NAS, you must enter a device name.

2. After you enter the device name at the *OK TO PRINT* prompt, the system prints the NAS to the printer you named.

3. For samples of the Uniformed Services Medical Treatment Facility Nonavailability Statement (NAS), DD Form 1251 (automated version) - 1990), refer to Figure 7-17. Nonavailability Statement for an Enrolled Patient, page 7-26, and Figure 7-18. Nonavailability Statement for a Non-Enrolled Patient, page 7-27.

4. The system returns to the NAS History screen where you can issue another NAS for the same patient or quit. If you choose to quit, the system returns to the initial prompt. Refer to Figure 7-11. NAS History Screen, page 7-16.

Note: Keep a copy of each NAS on file. If the patient ID changes in CHCS after an NAS is issued, the system will not be able to find the NAS on DEERS. If you have a copy of the NAS, you can use the NAS number to access it on DEERS.

- **Functionality Interactions**

Interactive NAS processing cannot be performed unless DEERS is online. NAS reports generated by a previous run can be printed/listed from a copy of the report(s) residing on disk without accessing DEERS; i.e. DEERS need not be online.

- **Troubleshooting**

Problem - Claims are denied for an NAS. You log onto CHCS and access the patient's NAS History Screen and do not see the NAS in question.

Solution - The site may have inadvertently issued the NAS to the wrong family member. To check this, access the NAS by number and check the beneficiary name and birth date and the sponsor SSN to make sure the NAS is applied to the correct beneficiary. If the NAS has been applied to the wrong family member, cancel the incorrect NAS and issue a new NAS for the correct family member.

Problem - DEERS does not display a patient's NAS if a conditional NAS is issued when the patient has a sponsor record on DEERS but their own eligibility record is not on DEERS.

S**olution** - Once the beneficiary's eligibility is established on DEERS, the NAS should display (provided the beneficiary is valid).

If the beneficiary seems to be correct, with the correct DOB, and the NAS is not conditional, call customer support to report the problem.

Problem - DEERS does not display a patient's NAS when you identify the patient by name.

Solution - Print a copy of the issued NAS to determine whether the patient's identification has changed in CHCS. Access the NAS by NAS number.

UNIFORMED SERVICES MEDICAL TREATMENT FACILITY NONAVAILABILITY STATEMENT (NAS)	REPORT CONTROL SYMBOL
PERSONAL DATA - PRIVACY ACT OF 1974 (PL 93-579 SUSC5F52A)	
1. NAS Number: 0120 7035 801 2. PRIMARY REASON FOR ISSUANCE: 8 - Care authorization outside network 3. MAJOR DIAGNOSTIC CATEGORY FOR WHICH NAS IS ISSUED: 22 BURNS	
4. PATIENT DATA:	
a. Name: STEWART,RENATE R d. ADDRESS: 232 DUCKSIDE DR HAMPTON, VIRGINIA 23669	b. DATE OF BIRTH: 22 Sep 48 c. SEX: F e. PATIENT CATEGORY: B - FAM MBR OF RETIRED f. OTHER NON CHAMPUS HEALTH INSURANCE: N - No Insurance
5. SPONSOR DATA:	
a. NAME: STEWART,JOHNNY E	b. SPONSOR'S OR RETIREE'S SSN: 457-76-9605
6. ISSUING OFFICIAL DATA:	
a. NAME: STONER,SUSAN c. SIGNATURE:	b. TITLE: TECHNOLOGIST d. PAY GRADE: GS18 e. DATE ISSUED: 04 Feb 1997
7. REMARKS (INDICATE BLOCK NUMBER TO WHICH ANSWER APPLIES.)	
1. STATUS: UNCONDITIONAL 1. ADMITTING FACILITY: ADMISSION DATE: REMARKS: 1: 2: 3:	
DD FORM 1251 (AUTOMATED VERSION) - 1990	

Figure 7-17. Nonavailability Statement for an Enrolled Patient

UNIFORMED SERVICES MEDICAL TREATMENT FACILITY NONAVAILABILITY STATEMENT (NAS)	REPORT CONTROL SYMBOL
PERSONAL DATA - PRIVACY ACT OF 1974 (PL 93-579 SUSC5F52A)	
1. NAS Number: 0120 7035 800 2. PRIMARY REASON FOR ISSUANCE: 4 - Facility temporarily not available 3. MAJOR DIAGNOSTIC CATEGORY FOR WHICH NAS IS ISSUED: 03 DISEASES AND DISORDERS OF THE EAR, NOSE AND THROAT	
4. PATIENT DATA:	
a. Name: PARKER,STACEY N d. ADDRESS: PT ADDR HAMPTON, VIRGINIA 23666	b. DATE OF BIRTH: 08 May 84 c. SEX: F e. PATIENT CATEGORY: A - FAM MBR OF ACTIVE DUTY f. OTHER NON CHAMPUS HEALTH INSURANCE: N - No Insurance
5. SPONSOR DATA:	
a. NAME: PARKER,THOMAS G	b. SPONSOR'S OR RETIREE'S SSN: 424-96-8396
6. ISSUING OFFICIAL DATA:	
a. NAME: STONER,SUSAN c. SIGNATURE:	b. TITLE: TECHNOLOGIST d. PAY GRADE: GS18 e. DATE ISSUED: 04 Feb 1997
7. REMARKS (INDICATE BLOCK NUMBER TO WHICH ANSWER APPLIES.)	
1. STATUS: UNCONDITIONAL 1. ADMITTING FACILITY: ADMISSION DATE: REMARKS: 1: 2: 3:	
DD FORM 1251 (AUTOMATED VERSION) - 1990	

Figure 7-18. Nonavailability Statement for a Non-Enrolled Patient

7.1.1.3 View NAS History

Refer to Section 4.3 Current DEERS Eligibility Display, View NAS History.

7.2 Reports for NAS (RNAS)

Menu Path: PAS System Menu → M → IMCP → RNAS

The Reports for NAS Menu (RNAS) contains the options which allow you to generate NAS reports for a DMIS ID within a user-specified time period. This reports are broken down by such criteria as MDC, branch of service, reason for issue, and patient category.

DEERS must be online to generate reports because NASs are not stored in CHCS. Also, because NAS reports must be downloaded from DEERS, you cannot run CHCS ad hoc reports on NAS data.

If a report has already been generated by a previous run of an NAS report option and saved as a spool document, CHCS stores the report. You can then reprint the NAS report, as necessary, without accessing DEERS; i.e., DEERS need not be online.

7.2.1 Printing a Report to a Spooled Document

1. At the *DEVICE* prompt, enter **SPOOL**. You are asked for the name of your spool document.

2. At the *Select SPOOL DOCUMENT NAME* prompt, enter the name of your document. Enter a name that is representative of the report you are printing; e.g., SERVICE_SUMMARY, NAS_STAT, REASON_PATCAT, or REASON_SUMMARY.

3. At the *Are you adding '<document name>' as a new SPOOL DOCUMENT?* prompt, enter **Y**.

4. At the *SPOOL DOCUMENT EXPIRATION DATE: <date>//* prompt, press <Return> to accept the default date or enter a date when the system should automatically delete this document.

7.2.2 Printing a Spooled Document

The Spooling Menu [ZISPLMGR] is used to list, print, and delete spooled documents. Refer to Figure 7-19. Spooling Menu [ZISPLMGR], page 7-29. You can request that your system administrator add this option to your secondary menu. Once added to your secondary menu, you can access this option from any menu by entering SPO.

```
Delete A Spool Document
          List Spool Documents
          Print A Spool Document

Select Spooling Menu Option:
```

Figure 7-19. Spooling Menu [ZISPLMGR]

1. Access the Spooling Menu option.
2. At the *Select Spooling Menu Option* prompt, enter **P**.
3. At the *Select SPOOL DOCUMENT NAME* prompt, enter the name of your spooled document; e.g., NAS_STAT. You may enter ?? to view a list of spooled documents.
4. At the *Number of Copies: 1//* prompt, press <Return> to print one copy or enter the number of copies you want to print.
5. At the *Output to* prompt, enter the name of the printer where you want the document to print.
6. Press <Return> to exit the Spooling Menu option.

7.2.3 Branch of Service Summary Report (BNAS)

Menu Path: PAS System Menu → M → IMCP → RNAS → BNAS

- **Contents**

This report lists the total number of NASs issued under a given DMIS ID in a user-specified month, broken down by MDC and branch of service. Running this report requires that DEERS be online. If the report for the given DMIS has not yet been generated, the system accesses DEERS to query the DEERS database and generate the report. You may request data up to four months in the past. Refer to Figure 7-20. Branch of Service Summary Report, page 7-32. Once downloaded, multiple copies may be printed. Refer to Section 7.2 Reports for NAS (RNAS), page 7-28; through Section 7.2.2 Printing a Spooled Document, page 7-29.

> **Note:** The system displays the Processing DEERS Request screen while report generation is in progress.

- **Use/Frequency**

Monthly or as needed.

- **Report Sample**

Refer to Figure 7-20. Branch of Service Summary Report, page 7-32.

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NONAVAILABILITY STATEMENTS
BRANCH OF SERVICE SUMMARY REPORT

DMIS ID: 0124 NH PORTSMOUTH
Month/Year: Feb 1996

DIAGNOSTIC CODE/DESCRIPTION	USA	USN	USAF	USMC	USCG	NOAA	PHS	UNK	TOTAL
0l NERVOUS SYSTEM	001	023	000	000	000	000	000	000	024
02 EYE	000	000	001	000	001	000	000	000	002
03 EAR. NOSE, AND THROAT	000	000	000	000	000	000	001	000	001
04 RESPIRATORY SYSTEM	001	000	001	000	000	000	000	000	002
05 CIRCULATORY SYSTEM	001	001	001	001	000	000	000	000	004
06 DIGESTIVE SYSTEM	000	002	000	000	000	000	000	000	002
07 HEPATOBILIARY & PANCREA	001	000	000	000	000	000	000	000	001
08 MOSCULOSKELETAL	001	000	000	000	000	000	000	000	001
09 SKIN & BREAST	000	000	000	000	001	000	000	000	001
l0 ENDOCRINE/NURT/METABOL	000	000	001	000	000	000	000	000	001
ll KIDNEY & URINARY	001	001	000	000	000	000	000	000	002
12 MALE REPRODUCTIVE	000	000	000	000	000	000	000	001	001
13 FEMALE REPRODUCTIVE	000	000	000	000	000	001	000	000	001
14 PREGNANCY	143	027	006	209	001	023	300	000	719
15 NEWBORNS	000	001	000	000	000	000	000	000	001
16 BLOOD	001	000	000	000	000	000	000	002	003
17 MYELOPROLIFERATE	000	002	000	000	000	000	000	000	002
18 INFECTIOUS DISEASES	000	000	000	007	000	000	000	000	007
19 MENTAL DISEASES	015	008	005	005	000	000	000	000	033
20 ALCOHOL & DRUG USAGE	000	001	001	000	000	000	000	000	002
21 INJURIES & POISONINGS	000	001	000	000	000	000	000	000	001

```
 61 GYN LAPAROSCOPY                 003  000   000   002   000   000 000 000
005
 62 CATARACT REMOVAL                001  001   000   000   001   000 000 000
003
 63 GI ENDOSCOPY                    001  007   003   000   001   000 089 000
101
 64 MYRINGOTOMY/TYMPANOTOM          000  000   007   000   003   000 000 072
082
 65 ARTHROSCOPY                     000  000   000   000   000   001 000 000
001
 66 DILATION & CURETTAGE            000  000   001   000   000   000 000 000
001
 67 TONSILLECTOMY/ADENOID           003  000   002   000   000   002 000 000
007
 68 CYSTOSCOPY                      003  000   000   000   000   000 000 000
003
 69 HERNIA REPAIR                   021  000   037   000   016   008 001 000
083
 70 NOSE REPAIR                     000  000   000   000   000   000 000 001
001
 71 LIGATION                        003  000   000   002   000   000 000 000
005
 72 STRABISMUS REPAIR               000  000   001   001   000   000 000 000
002
 73 BREAST MASS EXCISION            000  000   000   000   001   000 000 000
001
 74 NEUROPLASTY                     000  000   000   000   000   000 000 001
001

TOTAL FOR ALL DIAGNOSTIC CODES:    210  075   067   227   025   035 391 077
1208
```

Figure 7-20. Branch of Service Summary Report

7.2.4 NAS Statistical Report (NNAS)

Menu Path: PAS System Menu → M → IMCP → RNAS → NNAS

- **Contents**

This statistical report, for a specified DMIS ID, shows the total number of NASs generated, the total number canceled, and the difference between the two. These three totals are shown for both the user-specified current month and the most recent prior month. This option functions only when DEERS is online.

If the report for the given DMIS ID and the current month has not yet been generated, the system accesses DEERS to query the DEERS data base and generate the report. Refer to Figure 7-21. Monthly Statistical Report, page 7-34. Once downloaded, multiple copies may be printed. Refer to Section 7.2 Reports for NAS (RNAS), page 7-28; through Section 7.2.2 Printing a Spooled Document, page 7-29.

> **Note:** The system displays the Processing DEERS Request screen while report generation is in progress.

- **Use/Frequency**

Monthly or as needed.

- **Report Sample**

Refer to Figure 7-21. Monthly Statistical Report, page 7-34.

```
TRIPLER ARMY MEDICAL CENTER                          15 Apr 1996@1354 Page 1
                                NONAVAILABILITY STATEMENTS
                                MONTHLY STATISTICAL REPORT
DMIS ID: 0124 NH PORTSMOUTH                              Month/Year: Apr 1993
================================================================================
=
                                    Total     Total        Total Issued Less
                                    Issued    Canceled    Total Canceled
--------------------------------------------------------------------------------
-

     Current Month                    692         011             681

     Previous Month                  1232         042            1190
```

Figure 7-21. Monthly Statistical Report

7.2.5 Reason for Issue by Patient Category Report (PNAS)

Menu Path: PAS System Menu → M → IMCP → RNAS → PNAS

- **Contents**

This report lists the total number of NASs in a given DMIS ID for a given reason for issue, for a given month. The report displays the number of NASs issued for each MDC within each Issue Reason. A total is given for each patient category. Running this report requires that DEERS be online.

If the report for the given DMIS ID, reason for issue, and the current month has not yet been generated, the system accesses DEERS to query the DEERS data base and generate the report. Refer to Figure 7-22. Reason for Issue by Patient Category Report, page 7 7-36. You may request data for up to four months in the past, including the current month. Once downloaded, multiple copies may be printed. Refer to Section 7.2 Reports for NAS (RNAS), page 7-28; through Section 7.2.2 Printing a Spooled Document, page 7-29.

> **Note:** The system displays the Processing DEERS Request screen while report generation is in progress.

- **Use/Frequency**

Monthly or as needed.

- **Report Sample**

Refer to Figure 7-22. Reason for Issue by Patient Category Report, page 7-36.

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NONAVAILABILITY STATEMENTS
REASON FOR ISSUE BY PATIENT CATEGORY

Issuing DMIS ID: 0124 NH PORTSMOUTH Month/Year: Feb 1993

Reason for Issue: Medically Inappropriate

DIAGNOSTIC CODE/DESCRIPTION	FAM MBR AD	RET	RET	FRM SP	SURV	TOTAL
0l NERVOUS SYSTEM	001	023	000	000	000	024
02 EYE	000	000	001	000	001	002
03 EAR, NOSE, AND THROAT	000	001	000	000	000	001
04 RESPIRATORY SYSTEM	001	000	001	000	000	002
05 CIRCULATORY SYSTEM	001	001	001	001	000	004
06 DIGESTIVE SYSTEM	000	002	000	000	000	002
07 HEPATOBILIARY & PANCRE	001	000	000	000	000	001
08 MUSCULOSKELETAL	001	000	000	000	000	001
09 SKIN & BREAST	000	000	000	000	001	001
10 ENDOCIiINE/NURT/METABOL	000	000	001	000	000	001
ll KIDNEY & URINARY	001	001	000	000	000	OD2
12 MALE REPRODUCTIVE	001	000	000	000	000	001
13 FEMALE REPRODUCTIVE	000	001	000	DOO	000	001
14 PREGNANCY	143	027	006	209	201	586
15 NEWBORNS	101	001	074	213	072	461
16 BLOOD	001	000	000	002	000	003
17 MYELOPROLIFERATE	000	002	000	000	000	002
18 INFECTIOUS DISEASES	000	000	000	007	000	007
19 MENTAL DISEASES	015	008	005	005	000	033
20 ALCOHOL & DRUG USAGE	000	001	001	000	000	002
21 INJURIES & POISONINGS	000	001	000	000	000	001
61 GYN LAPAROSCOPY	003	000	000	002	000	005
62 CATARACT REMOVAL	001	001	000	000	001	003
63 GI ENDOSCOPY	001	007	003	000	001	012
64 MYRINGOTOMY/TYMPANOTOM	000	072	007	000	003	082
65 ARTHROSCOPY	000	001	000	000	000	001
66 DILnTIoN & CURETTAGE	000	000	001	000	000	001
67 TONSILLECTOMY/ADENOID	003	000	002	000	000	005
68 CYSTOSCOPY	003	000	000	000	000	003
69 HERNIA REPAIR	021	000	037	000	016	074
70 NOSE REPAIR	000	007	000	000	000	007
71 LIGATION	003	000	001	001	000	002
73 BREAST MASS EXCISION	000	000	000	000	001	001
74 NEUROPLASTY	000	000	000	003	000	003
Total:	312	157	141	445	297	1352

Figure 7-22. Reason for Issue by Patient Category Report

7.2.6 Reason for Issue Summary Report (SNAS)

Menu Path: PAS System Menu → M → IMCP → RNAS → SNAS

- **Contents**

This report lists the total number of NASs in a given DMIS ID in a given month, and shows each MDC within each Issue Reason with subtotals by issue reason. The report also gives an overall total for the specified DMIS ID. Running this report requires that DEERS be online.

If the report for the given DMIS ID and the current month has not yet been generated, the system accesses DEERS to query the DEERS database and generate the report. Refer to Figure 7-23. Reason for Issue Summary Report, page 7-39. Once downloaded, multiple copies may be printed. Refer to Section 7.2 Reports for NAS (RNAS), page 7-28; through Section 7.2.2 Printing a Spooled Document, page 7-29.)

> **Note:** The system displays the Processing DEERS Request screen while report generation is in progress.

- **Use/Frequency**

Monthly or as needed.

- **Report Sample**

Refer to Figure 7-23. Reason for Issue Summary Report, page 7-39.

TRIPLER ARMY MEDICAL CENTER 15 Apr 1996@1420 Page 1

NONAVAILABILITY STATEMENTS
REASON FOR ISSUE SUMMARY REPORT

Issuing DMIS ID: 0124 NH PORTSMOUTH Month/Year: Feb 1993

REASON FOR ISSUE/ DIAGNOSTIC CODE/DESCRIPTION	NORM	RET	CHR	C/R	TOTAL
Facility or professional capability permanently non available					
19 MENTAL DISEASES	021	057	000	000	078
20 ALCOHOL & DRUG USAGE	000	023	001	003	026
Subtotal:	021	080	001	003	104
Facility temporarily not available					
04 NERVOUS SYSTEM	001	020	000	082	103
05 CIRCULATORY SYSTEM	041	002	000	027	070
07 HEPATOBILIARY & PANCREAS	000	001	072	013	086
08 MUSCULOSKELETAL	007	001	000	007	015
ll KIDNEY & URINARY	010	023	008	001	042
14 PREGNANCY	005	002	014	000	021
15 NEWBORNS	000	001	000	003	004
19 MENTAL DISEASES	019	033	002	023	077
20 ALCOHOL & DRUG USAGE	002	002	035	000	039
21 INJURIES & POISONINGS	000	041	000	000	041
62 CATARACT REMOVAL	001	070	000	039	110
63 GI ENDOSCOPY	005	000	0~3	022	060
65 ARTHROSCOPY	001	049	003	000	053
68 CYSTOSCOPY	007	000	001	000	008
Subtotal:	099	245	168	217	729
professional capability temporarily not available					
05 CIRCULATORY SYSTEM	013	040	001	021	075
08 MUSCULOSKELETAL	001	000	000	003	004
ll KIDNEY & URINARY	000	017	021	022	060
14 PREGNANCY	049	001	002	011	063
62 CATARACT REMOVAL	032	009	001	001	043
63 GI ENDOSCOPY	006	001	016	038	061
65 ARTHROSCOPY	021	000	005	000	026
68 CYSTOSCOPY	001	042	001	040	084
72 STRABISMUS REPAIR	007	001	001	013	012
Subtotal:	130	111	048	149	438
TOTAL:	250	436	217	369	1272

Figure 7-23. Reason for Issue Summary Report

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has been left blank
intentionally

CHCS: MCP DESKTOP USER GUIDE

Appendix A
Reference Materials

Appendix A. Reference Materials

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Table A-1. File Access Codes for Common, PAS, and MCP Files

File #	File Name	Access		
		Read	Write	LAYGO
Common Files				
40.8	Medical Center Division	S	#	#
45.7	Department and Service		#	#
8119	MEPRS Codes		#	#
5.8002	Zip Code		#^	#^
40.5	Holiday		#	#
44	Hospital Location	Ss	Ss	Ss
7	Provider Class		#	#
3.1	Title	@	#	#
3	User		#	#
6	Provider		#P	#P
8111	Unit Ship ID		#	#
PAS Files				
44.5	Appointment Type	Ss	S	
44.6	PAS Profile Template	Ss	S	S
MCP Files				
8557	MCP Agreement Modifications	S	S	S
8573	MCP Agreement Type	Ss	^	^
8563	MCP Alternate Care Value	Ss	^	^
8561	MCP Assignment Reason	Ss	S	S
8565.5	MCP Beneficiary Categories	Ss	^	^
8563.5	MCP CHAMPUS Dental Code	@	@	@
8564	MCP Disenrollment Reason	Ss	S	S
8572	MCP Enrollee Lockout Override Reason	Ss	Ss	Ss
8582	MCP Enrollment Block Reasons	SsZ	SsZ	SsZ
8575	MCP Entitlement Discrepancy Codes		@	@
8560	MCP Form Text	S	S	S
8555	MCP Office	Ss	Ss	Ss
8556	MCP HCF	Ss	Ss	Ss
8577	MCP Zip Code Combination	Ss	Ss	Ss

File #	File Name	Access		
		Read	**Write**	**LAYGO**
8566	MCP Facility Type	Ss	S	Ss
8583	NAS Issuing Officer	S	S	S
8552	MCP Patient	Ss	Ss	Ss
8565	MCP Patient Type	Ss	^	^
8574	MCP Policy Holder	Ss	Ss	Ss
8576	MCP Provider Type	S	^	^
8567	MCP Provider Group	Ss	S	
8568	Professional Category	Ss	S	S
8569	Military Status	Ss	S	S
8550	MCP Provider Group	Ss	S	
8553	MCP Place of Care	Ss	S	
8551	MCP Provider	Ss	S	S
8554	MCP Referral	Ss	Ss	Ss
8570	MCP Appointment Refusal Reason	S	@	@
8578	MCP Parameters	S	S	S
8579	MCP Unit PCM	Ss	Ss	@
8582	NAS Issue Reason	#	^	^
PAD Files				
8064	Insurance Company		Aa	Aa
39.4	Embosser Format	#DdSs	#DS	#DS

Table A-2. Access Code Legend

Each functionality has its own file security code, which is listed as an uppercase letter and a lowercase letter. These define either a manager/supervisor or clerk/end-user access to subsystem files. Generally, the uppercase code is assigned to an individual with high accountability. The lowercase code is assigned to an individual with less accountability.

File Security	Functional Area
A,a	Medical Services Accounting (MSA) **Note:** In the MSA subsystem, a lowercase 'a' indicates supervisory access.
D,d	Patient Administration
S,s	Patient Appointment and Scheduling (PAS)
P,p	Pharmacy
@, #, ^, Z, z	Tools

Table A-3. MCP Security Keys

Security Key	Description
CPZ ADHOC	Allows holders to access the MCP Ad Hoc Report Menu (CP AD HOC REPORTING). This menu allows users to print, search, and inquire into file entries.
CPZ AGREEMENT	Allows holders to access the Agreement Type Enter/Edit [MCP AGREEMENT TYPE ENTER EDIT] option on the Provider Network File/Table Maintenance Menu [MCP HCP NET FILE MAINT MENU]. Allows users with the CPZ FILE security key to edit the agreement types for the MTF. This key should only be assigned to a few select MCP File and Table POCs.
CPZ AGRMOD	Allows holders to access the Modify Group Agreement Effective Date [MCP AGREEMENT MODIFICATION] option on the Provider Network Management Menu [MCP NET MAINTAIN MENU]. This is a central processing unit (CPU)-intensive option and should only be assigned to a few select MCP File and Table POCs.
CPZ AUTO ENROLL	Allows holders to see the *Auto Enroll?* prompt at the end of Mini Registration.
CPZ BATCH ENROLL	Allows holders to access the Batch Enroll Active Duty (BENR) option.
CPZ CASE	Allows holders to enter/edit case managers (non-network providers/exception providers) for patients. PAS users who hold the CPZ OHI security key in addition to this key have the capability to add case managers via the OHI option on the Demographics Display screen.
CPZ CCP	Allows holders to access the Managed Care Program Menu [MCP MAIN MENU] on the PAS Main Menu [SD PAS MAIN MENU]. All HCFs and MCP File and Table POCs should be assigned this key.
CPZ DISENROLL CANCEL-CORRECT	Allows holders to access the Disenrollment Cancellation/Correction (DCAN) option.
CPZ ENTITLEMENT CLEAR	Allows holders to see the Clear Entitlement Discrepancy action on the MCP Discrepancy Data screen.
CPZ FILE	Allows holders to access the File and Table for MCP Menu [MCP FILE TABLE MAINT MENU] on the Managed Care Program Menu [MCP MAIN MENU]. MCP File and Table POCs should be assigned this key.

Security Key	Description
CPZ IDENTIFY AD	Allows holders to access the Identify Potential Active Duty Candidates (IBER) and Delete Potential Candidate List (DBER) options.
CPZ LABEL	Allows holders to generate provider labels, and mailing labels for individual patients or by family (batch).
CPZ LOWCAP	Allows holders to downsize a provider's practice.
CPZ MCSC	Allows holders to use the Managed Care Support Contractor options on the MCP main menu.
CPZ NAS	Allows holders to access the Interactive NAS Processing Menu [MCP NAS MAIN MENU] option on the Managed Care Program Menu [MCP MAIN MENU]. This option allows users to enter non-availability statements (NASs).
CPZ NET	Allows holders to access the Provider Network Management Menu [MCP NET MAINTAIN MENU] option on the Managed Care Program Menu [MCP MAIN MENU]. MCP File and Table POCs should be assigned this key.
CPZ OHI	Allows PAS users to enter other health insurance (OHI) via the PAS Demographics Display Action Bar.
CPZ PARAMETERS	Allows holders access to the MCP Parameters file. Allows the site to set restrictions on enrollment mix and zip codes, and to determine if the site is going to run in Local Empanelment Mode or Full Enrollment Mode.
CPZ PCM AGR LOCK	Allows holders to assign active duty beneficiaries to network PCMs with the agreement types of NET and SUP.
CPZ PCM BATCH	Allows holders to access the Batch PCM Reassignment [MCP BATCH PCM REASSIGNMENT] option from the Managed Care Program Menu [MCP MAIN MENU]. This is a CPU-intensive task that should be restricted to selected personnel.
CPZ RENEW DIS BATCH	Allows holders to access the MCP Multiple Batch Renewal and Disenrollment Functions (MENR) menu.
CPZ TSC LOADER	Allows holders to access the TSC Loader options.
CPZ ZIP	Allows holders to override a patient's residential zip code if that zip code has been defined as being outside the enrollment (catchment) area for the site.

MCP TaskMan Options

Menu Path: Systems Manager Menu (EVE) → TM → STT

(**Note:** Beginning with CHCS V4.6, the CP ENROLLMENT BULLETIN runs automatically without user intervention.)

CP Enrollment Bulletin

Frequency/Time of Day: Daily/Evening

Description:

1. The CP Enrollment Bulletin checks the MCP Patient file for beneficiaries with a Conditional Enrolled status. Then the system transmits a DEERS eligibility request every 7 days after the Enrollment Start Date up to the 120th day of the conditional enrollment period..

2. With an Eligible response from DEERS, the system changes the MCP Beneficiary's MCP status from Conditional Enrolled to Enrolled the next time the CP Enrollment Bulletin runs.

3. If DEERS returns an ineligible response on the 120th day from the Enrollment Start Date, the system changes the MCP Beneficiary's MCP Status to Disenrolled on the 121st day. The End Enroll Date is changed to the MCP Enroll Date and the Disenrollment Reason becomes Enrollment Canceled (ED).

(**Note:** The Direct Care field displayed on the DEERS Eligibility screen is populated with the word Eligible when a beneficiary is found to be eligible and Not Eligible when a patient is ineligible.)

CP NAS Daily Cleanup

Frequency/Time of Day: Daily/Evening

Description: Purges temporary DEERS data held in CHCS for Non-availability statement (NAS) transactions.

CP NET HCP Bulletin

Frequency/Time of Day: Daily/Post midnight

Description: Performs checks on inactivated providers and notifies recipients of the CP HCP Inactivation Mail Bulletin. Also encourages Discrepancy Avoidance Report check.

CP NET POC Bulletin

Frequency/Time of Day: Daily/Evening

Description: Same as CP NET HCP Bulletin, but for inactivated places of care.

CP UIC Enrollee Maintenance

Frequency/Time of Day: Weekly

Description: Checks all MCP enrollees for change of Unit Identification Code (UIC), and updates all UIC cross references. Verifies code is valid in Unit Ship ID file. If Unit Ship ID code is invalid, prompts user to run discrepancy report.

CP Update Candidate File

Frequency/Time of Day: Daily/Evening

Description: Checks changes in and updates the potential active duty patient candidate file to ensure readiness for enrollment.

CP Update ENR End Date -- OBSOLETE

Frequency/Time of Day: Daily

Description: The DEERS ELIG/REG RESPONSE file stored the DEERS eligibility responses that contained the eligibility end date. This stored information was used to update the active duty end enrollment date each time a DEERS eligibility check was performed in PAS/MCP. This prevented overlapping enrollment episodes in DEERS. The system now automatically checks the eligibility end date with active duty patient enrollment end dates during each DEERS eligibility transaction. If the date does not match, the system modifies the enrollment end date to match with eligibility end date.

CP Reciprocal Disenroll Process

Frequency/Time of Day: Daily

Description: Sends request to DEERS to retrieve the list of those reciprocally disenrolled from their Defense Medical Information Systems Identification (DMIS ID) that day. This, in turn, starts an automatic disenrollment for all the names received.

CP Enrollment Update --- OBSOLETE

Frequency/Time of Day: Daily

Description: This routine ran if the enrollment mode was switched from local empanelment to DEERS Enrollment Mode. When this occurred, a batch job was initiated to reprocess all current AD enrollments. This function is now addressed with the CP Enrollment Bulletin.

MCP Mail Group Bulletins

Menu Path: Systems Manager Menu (EVE) → MM → EBUL

Bulletins:

CP AD BATCH ENR COMPLETE – States that the Batch enroll AD candidates option has been completed.

CP AD BATCH UPD COMPLETE – Notifies the mail group that the process for updating potential AD enrollment candidate file is complete.

CP AGREEMENT MODIFICATION – Notifies the mail group and the user who changed the agreement start date for an existing agreement.

CP BATCH IDENTIFY AD ENR – Notifies the mail group once the job Identify Potential Active Duty Candidates is completed (IPADC).

CP BATCH PCM – Notifies the group when a batch job reassigning beneficiaries from one PCM to another under the Batch PCM option is completed.

CP BATCH PCM ABORT – Notification that the batch job for reassigning beneficiaries from one PCM to another was unsuccessful.

CP BATCH DISEN COMPLETE – Notifies the user when the Batch Disenrollment is complete.

CP BATCH DISENROLL COMPLETE – Notifies that the process of changing from DEERS enrollment (Full Enrollment) to LOCAL EMPANELMENT has completed.

CP ENR DIV CHANGE – Notifies the user and mail group when the option CHANGE ENROLLING DIVISION is complete. Used with DMIS Realignment.

CP HCP INACTIVATION DATE – Generated daily to show any inactive providers, and serves as a reminder to check the Discrepancy Avoidance report.

CP HCP INACTIVATION – Generated when a provider is inactivated or reactivated from one provider group or from all provider groups.

CP INVAILD ENROLLMENT – Notification that beneficiaries were found to have discrepancies between DEERS and CHCS during an Enrollment/Disenrollment transaction. This bulletin recommends that the Enrollment/Disenrollment Discrepancy report be printed to reserve and correct the discrepancies.

CP MULTIPLE BATCH PCM – Notifies a group when a batch job for reassigning beneficiaries from one PCM to multiple PCMs under the Batch PCM option has completed.

CP NEW UIC CODE – Notifies recipients that a new UIC code downloaded from DEERS does not match an entry in the Unit/Ship ID file. It recommends updating the file and editing the patient's mini-registration.

CP PCM REACHED MAX CAPACITY – Generated during Auto Enrollment if the user accepts the defaulted PCM and that PCM has reached maximum overall capacity or maximum active duty capacity. A warning displays for the user who may continue with the enrollment by assigning an alternate PCM.

CP POC INACTIVATION – Generated when a place of care is inactivated.

CP POC INACTIVATION DATE – Generated daily to show any discrepancies that exist for places of care that have been inactivated.

CP RECIPROCAL DISENR COMPLETE – Generated when the Auto Reciprocal Disenrollments have completed and whether discrepancies have been identified. The spool document of discrepancies will be deleted after 14 days. A bulletin is also generated when no discrepancies are noted.

CP RENEW AGREEMENT BATCH PCM – Notifies the group that an agreement was RENEWED and the listed providers had their PCM patients reassigned.

CP RENEW AGREEMENT NON-PART – Notifies the group that an agreement was RENEWED and the listed providers are NON-PARTICIPANTS in the renewed agreement with PCM patients assigned.

CP RENEW AGREEMENT W-OUT BATCH – Notifies that an agreement was RENEWED and the listed providers have PCM patients that were not reassigned. They were no reassigned either because the user did not have the key to perform the function or the PCM was not selected to have their patients reassigned.

CP UIC MAINT RPT AVAIL – Notifies the group that the UIC Maintenance report is available for printing. The report identifies those enrolled AD members whose UIC is invalid in CHCS or whose UIC has been changed.

CP UIC WITHOUT PCM – Generated during Auto Enrollment if the UIC matches an entry in the Unit/Ship ID file but has not been linked to a PCM (UIC/PCM Link). A user may still complete the enrollment by directly assigning a PCM.

CP INACTIVATE UIC IN AUTO ENROLLMENT – Notification that an auto enrollment was performed for a patient whose UIC has been inactivated. It recommends that the patient's mini registration be updated.

CP BATCH RENEW COMPLETE – Notification that the process to Batch Renew Enrollment has completed and to generate the Batch Renewal Disenrollment Roster.

CP BATCH DISEMPANEL COMPLETE – Notification that non-active duty members have been Disempaneled after switching from Local Empanelment to the DEERS Enrollment mode.

CP PARAMETERS – Notification that the dates to perform annual and monthly eligibility checks are incomplete in the MCP PARAMETERS option.

CP DRS SYNC RPT – Notification that the CHCS/DEERS Enrollment Synchronization Report has run to completion and is available for printing through the Spooling Menu (SPF) on the Secondary Menu. Refer to Section 7.2.2 for instructions on printing spooled files.

Table A-4. Direct Care Provider Agreement Types and Eligible Patient Types

Agreement Types		Patient Types	
CON	CONTRACT	AD	Active Duty
		SCD	Supplemental Care Diagnosis
		MCD	MCP/Non CHAMPUS Eligible
		MCA	MCP/Active Duty
		MED	Medicare
		MCP	MCP/CHAMPUS Eligible
		OTH	Other
		CHA	CHAMPUS
MTF	MTF STAFF	AD	Active Duty
		SCD	Supplemental Care Diagnosis
		MCD	MCP/Non CHAMPUS Eligible
		MCA	MCP/Active Duty
		MED	Medicare
		MCP	MCP/CHAMPUS Eligible
		CHA	CHAMPUS
		OTH	Other
PIC	PARTNER INTERNAL	MCP	MCP/CHAMPUS Eligible
		CHA	CHAMPUS
SUP	SUPPLEMENTAL CARE/ DIAGNOSTIC SERVICE	AD	Active Duty
		SCD	Supplemental Care Diagnosis
		MCD	MCP/Non CHAMPUS Eligible
		MCA	MCP/Active Duty
		MED	Medicare
		MCP	MCP/CHAMPUS Eligible
		OTH	Other
		CHA	CHAMPUS

Table A-5. External (Non-MTF) Provider Agreement Types and Eligible Patient Types

Agreement Types		Patient Types	
CON	CONTRACT	AD	Active Duty
		SCD	Supplemental Care Diagnosis
		MCD	MCP/Non CHAMPUS Eligible
		MCA	MCP/Active Duty
		MED	Medicare
		MCP	MCP/CHAMPUS Eligible
		OTH	Other
		CHA	CHAMPUS
NET	CIVILIAN NETWORK PROVIDER	AD	Active Duty
		SCD	Supplemental Care Diagnosis
		MED	Medicare
		MCP	MCP/CHAMPUS Eligible
		CHA	CHAMPUS
PEX	PARTNER EXTERNAL	MCP	MCP/CHAMPUS Eligible
		CHA	CHAMPUS
SUP	SUPPLEMENTAL CARE/ DIAGNOSTIC SERVICE	AD	Active Duty
		SCD	Supplemental Care Diagnosis
		MCD	MCP/Non CHAMPUS Eligible
		MCA	MCP/Active Duty
		MED	Medicare
		MCP	MCP/CHAMPUS Eligible
		OTH	Other
		AD	Active Duty
		CHA	CHAMPUS

Table A-6. Non-Network/Exception Provider Agreement Type and Eligible Patient Types

Agreement Types		Patient Types	
NON	NON-NETWORK EXCEPTION	SCD	Supplemental Care Diagnosis
		MCP	MCP/CHAMPUS Eligible
		CHA	CHAMPUS

Table A-7. ACV Codes

Code	Description
A	TRICARE PRIME (Active-Duty)
B	CHAMPVA (OCONUS)
C	CHAMPUS
D	MEDICARE DEMONSTRATION
E	TRICARE PRIME (CHAMPUS)
K	CATCHMENT AREA MGT
N	DIRECT CARE ONLY
S	CHCBP - Continued Health Care Benefit Program
U	USTF - Uniformed Service Treatment Facility
V	CHAMPVA (CONUS)

Table A-8. DEERS Discrepancy Codes

If you send an enrollment or disenrollment transaction and receive a discrepancy code in return, first correct the data. Then repeat the transaction by returning through the enrollment screens or re-doing the disenrollment with the same dates.

It is not always apparent what data needs to be corrected. This table lists all DEERS data discrepancy codes, a brief description of each, and some of the possible causes for and suggestions for clearing each discrepancy. **Note:** This is not a comprehensive list of possible discrepancy causes.

Discrepancies that prevent you from receiving a completed NAS Display screen are marked with an asterisk (*) beside the code number. You should not receive these NAS-related codes when processing enrollments/disenrollments.

Code	Discrepancy	Possible Causes, Suggestions for Clearing Enrollment/Disenrollment Discrepancies, and NAS-Related Areas
00	More reciprocal disenrollment data to receive	Used for the nightly receipt of reciprocal disenrollments at the losing site. If you see this code on the Enrollment/Disenrollment Discrepancy report, log a support center call.
01	SSN not found in DEERS database - Verify SSN	The patient's sponsor is not on the DEERS database. Verify the SSN in CHCS. If correct, send the patient to the personnel office on base to register in DEERS.
02	SSN found - No dependents found	The patient's sponsor is on the DEERS database, but the patient (who is a family member) is not on DEERS. Send the patient/sponsor to the personnel office on base to register in DEERS.
03	DEERS files closed	This happens occasionally on DEERS. Repeat the enrollment or disenrollment transaction.
04	Input length greater than maximum	Log a CHCS Support Center call.
05	Invalid block ID	Used for the nightly receipt of reciprocal disenrollments at the losing site. If you receive this code, log a support center call.
06	Invalid disenrollment flag	See 05.
09	Invalid PCM contractor code	The PCM contractor code, which is entered in site MCP Parameters file is not part of the DEERS table for PCM contractor codes. Log a DEERS Support Center call.

10	Invalid transaction type	Either an MCP or TOOLS software problem. Log a Support Center call.
11	Invalid MTF site code	Check the site code in the DEERS Parameters file on the Site Manager menu chain. Verify your site code with the DEERS Support Center.
12	Invalid sponsor SSN	Should not be received as an enrollment/disenrollment response. Log a Support Center call.
13	Invalid patient DOB	May be caused by a DOB entered as just month/year (no day).
14	Invalid family sequence number	Should not be received on an enrollment/disenrollment response.
15	Invalid patient FMP	See 14.
16	Invalid DDS	See 14.
17	Invalid UCA	See 14.
18	Invalid patient street	See 14.
19	Invalid patient city	See 14.
20	Invalid patient state	See 14.
21	Invalid patient country	See 14.
22	Invalid patient ZIP code	See 14.
23	Invalid eligibility code	See 14.
24	Invalid eligibility end date	See 14.
25	Invalid eligibility end reason	See 14.
26	Invalid User ID	See 14.
27	Invalid country code	See 14.
28	Invalid state code	See 14.
29	Invalid address update switch	See 14.
30	Invalid eligibility override code	See 14.
31	Invalid home phone number	See 14.
32	Invalid eligibility start date	See 14.
33	Invalid registration - Patient not found	See 14.

35	Invalid cancel - Start and end dates not equal	Repeat the disenrollment transaction and make sure the disenrollment date is the same as the enrollment start date. If patient is still on the discrepancy report the next day, log a Support Center call.
36	Invalid cancel - Patient not enrolled	This code is interpreted as a "GOOD" code in the CP ENROLLMENT BULLETIN. If you see a patient MCP status of IE or ID and this is the discrepancy, log a Support Center call.
37	Invalid cancel - DMIS does not match	This means that either the DMIS ID for the Enrolling division was changed or the Enrolling Division was changed and an update transaction was not sent to DEERS to change the DMIS ID. If you have a lot of these and they are in the same Enrolling Division, you may want to run the DMIS Update DMIS ID option for that Enrolling Division. If it is just one patient, you can change the Enrolling Division to some other division and file the data. Re-enter the EENR option and then change the Enrolling Division back to the correct division. This forces two update transactions to DEERS, sequentially changing the DMIS ID to that of the Enrolling Division. Then repeat the cancel transaction. Note: This correction process is not valid for CHCS versions prior to V4.5. If that does not work, check to see if the Enrolling Division is using a DMIS ID that is not in the DEERS DMIS ID table. Suspect this especially if you have a lot of discrepancies relating to DMIS Ids. Log a DEERS support center call.

38	Invalid enrollment date change - Patient not enrolled	Caused by an update enrollment transaction sent to DEERS to change the start or end date, but the original enrollment transaction failed DEERS edits and was, therefore, never recorded on DEERS. Return through the enrollment screens and re-send the enrollment transaction. If that does not work, log a Support Center call.
39	Invalid enrollment - Not eligible for plan	Two things may cause this. First, the patient's Patient Category is wrong on CHCS and therefore the wrong ACV is sent as part of the enrollment transaction. The best way to determine if this is the case is to do an on-line eligibility check. If the patient is active duty, the non-enrolled ACV is N. If the patient is not active duty, the non-enrolled ACV is usually C. After doing the eligibility check, access the Inquire to File Entries (IFE) option on the FileMan Menu (FM), and check in the Patient file to see the DEERS SPONSOR STATUS field. R and O are retired values. A and B are active duty values. Correct the patient category on CHCS and re-do the enrollment. You must manually change the MCP Patient Type when you go through the enrollment screens for the correction. Second, bad data is on DEERS. The DEERS database is case-sensitive. If the ACV is recorded in lowercase, the enrollment transaction will be rejected even though CHCS is sending the correct ACV value. Log a DEERS Support Center call.
40	Invalid enrollment - Plan type not A, D, or E	Usually caused by a "hiccup" in the transmission to DEERS, which puts a garbage character into the transmission string. Repeat the transaction. If the patient is still on the Discrepancy Report the next day, log a Support Center call.
41	Invalid cancel - Canceling DMIS does not match	Follow tips in 37.

42	Invalid enrollment - DMIS does not match	Follow tips in 37, except that in enrollment you don't have to change the Enrolling Division. Just go through the screens and send another enrollment transaction.
43	Invalid enrollment date change - Invalid plan type	This occurs when you have changed the enrollment date and sent an update transaction, but the ACV transmitted as the update was incorrect. Check the Patient Category and compare it to the data from an eligibility transaction. See 39 for discussion of the eligibility data. An incorrect ACV may be transmitted when a patient category is changed after the initial enrollment and before the enrollment date change. Also try just returning through the screens to send the transaction again.
44	Invalid disenrollment - Invalid plan type	Similar to 43.
45	Invalid disenrollment - DMIS does not match	Similar to 37. May also result from another site reciprocally enrolling the patient (thereby changing the DMIS ID on DEERS), but the reciprocal process to disenroll the patient at your site did not happen. Repeat the eligibility transaction and check the DMIS ID field. If you are using CHCS V4.5, you can look at the history segments on the DEERS eligibility response. If this is the case, you will see an earlier segment showing your site's DMIS ID and a new segment showing the other DMIS ID. If true, disenroll as of the ACV start date shown for the new DMIS ID. You will receive a 52 discrepancy on the transaction, but CHCS considers that to be a "GOOD" code. See 52 for details.
46	Invalid enrollment - Start date prior to October 1, 1992	You should never see this discrepancy code because CHCS prevents entry of an enrollment start date prior to 1 Oct 92.
47	Invalid disenrollment date - Patient not disenrolled	You sent an update disenrollment transaction but the original disenrollment transaction was never recorded on DEERS. Repeat the disenrollment.
48	Invalid update - Not currently enrolled	Similar to 47. Go through the enrollment screens again and repeat the transaction.

49	Invalid update - Not eligible	Cause unknown.
50	Invalid site Id	Log a DEERS Support Center call.
51	Invalid site - Not CCP site	Log a DEERS Support Center call.
52	Invalid disenrollment - Patient not enrolled	You not see this code since the CP ENROLLMENT BULLETIN has been modified to treat a 52 as a "GOOD" code. This change was made in CHCS V4.5 and was a Quick Fix to CHCS V4.31/4.32. If this code appears on your reports, you need QF 22650.
53	Invalid disenrollment date	Check the enrollment start/end dates and repeat the transaction.
54	Invalid disenrollment - Patient already disenrolled	The CP ENROLLMENT BULLETIN treats this as a "GOOD" code for disenrollments. If you receive this code and the MCP Status is INVALID DISENROLLMENT, log a Support Center call.
55	Invalid site for enrollment	Log a DEERS Support Center call.
56	Invalid enrollment - Patient already enrolled	You receive this code if you enrolled someone as a regular enrollment, but it should have been a reciprocal enrollment/disenrollment. Repeat the enrollment transaction and be sure to repeat the DEERS check and get the Family Member screen so that you can invoke reciprocal. If that does not work, log a Support Center call.
57	Invalid Enrollment Eligible Code	Cause unknown.
58	Invalid enrollment - Patient not eligible for CCP	Cause unknown, but repeat the eligibility check and make sure you and DEERS agree on DEERS/Sponsor Status/Patient Category. Repeat the enrollment transaction. If that does not work, call the DEERS Support Center.
59	Invalid DOB/DDS	Should not see this code on an enrollment transaction.
60 *	Invalid DMIS number	The Enrolling Division DMIS ID (CHCS V4.5 or later) is not in the DEERS DMIS ID table. Log a DEERS Support Center call. NAS Issue Screen
61 *	Invalid reason for issue	Related to NAS functionality. If you receive this code when processing enrollments/disenrollments, log a CHCS Support Center call.
62 *	Patient Category does not match Patient Relationship	See 61. Related to NAS Issue Screen.
63 *	NAS number required	See 61. Related to NAS Issue Screen.
64 *	Med inapp city required	See 61. Related to NAS Issue Screen.

65 *	Med inapp state required	See 61. Related to NAS Issue Screen.
66 *	Med inapp ZIP required	See 61. Related to NAS Issue Screen.
67 *	Med inapp mileage required	See 61. Related to NAS Issue Screen.
68 *	Med inapp code required	See 61. Related to NAS Issue Screen.
69 *	Invalid Patient Category	See 61. Related to Mini Registration.
70 *	Invalid admission date	See 61. Related to NAS Issue Screen.
71 *	Admitting hospital required	See 61. Related to NAS Issue Screen.
72 *	Invalid major diagnostic category.	See 61. Related to NAS Issue Screen.
73 *	Issuing officer name required	See 61. Related to NAS Issue Screen.
74 *	Issuing officer grade required	See 61. Related to NAS Issue Screen.
75 *	Issuing officer title required	See 61. Related to NAS Issue Screen.
76 *	"J" type transaction required	See 61. Related to NAS Issue Screen.
77 *	Terminal ID required	See 61. Retransmit to DEERS
78 *	Invalid signature date	See 61. Related to NAS Issue Screen.
79 *	Invalid other insurance	See 61. Related to OHI.
80 *	Other insurance policy required	See 61. Related to OHI.
81 *	Other insurance co. required	See 61. Related to OHI.
82 *	Sponsor name required	See 61. Related to Mini Registration.
83 *	Patient name required	See 61. Related to Mini Registration.
84 *	Patient sex required	See 61. Related to Mini Registration.
85 *	Patient found on DEERS Conditional NAS Issue	See 61. Repeat DEERS Eligibility Query.
86 *	NAS record not found	See 61.
87 *	NAS already canceled	See 61.
88 *	Invalid monthly report date	See 61.
89 *	Unable to issue NAS	See 61. Related to NAS Issue Screen.
90 *	Patient address not on DEERS	See 61. Related to Mini Registration.
91 *	Invalid Monthly Report Type	See 61. Re-request Report.
92 *	Monthly Report not available for type/date requested	See 61. Re-request Report.
93 *	Patient state required on Conditional NAS	See 61. Related to Mini Registration.
94 *	Patient zip code required on Conditional NAS	See 61. Related to Mini Registration.

95 *	Issuing officer grade	See 61. Related to NAS Issue Screen.
96 *	Patient category does not match DDS	See 61. Related to Mini Registration.
97 *	Patient category not consistent with sponsor status	See 61. Related to Mini Registration.
98 *	Sponsor must be deceased for patient category of survivor	See 61. Related to Mini Registration.
99	Transaction complete	This is the DEERS response saying everything worked perfectly. You should not see this code on the Enrollment/Disenrollment Discrepancy report. If you do, log a Support Center call.
A1 *	Med inapp hospital required	See 61. Related to NAS Issue Screen.
A2	Successful reciprocal disenrollment; Invalid enrollment, patient not eligible	Repeat the eligibility check. If the patient appears to be eligible, check the patient category.
A3	Invalid cancel disenrollment - Patient not enrolled	
A4		
A5		
AA	No more reciprocal disenrollment data to receive	If you receive this code on an enrollment response, log a CHCS Support Center call.
ZZ	External DEERS database experienced a system error	Repeat the enrollment transaction. If you get this code twice, log a DEERS Support Center call.

Select DEERS ELIGIBILITY OVERRIDE CODE:

10 DEERS enrollment exception - billing determine response.

01 Care Denied - Not treated

02 Presented valid DD Form 1172 and valid ID card

03 Patient recently eligible (less than 120 days). Patient not on DEERS.

04 Sponsor recently entered active duty for greater than 30 days.

05 Newborn infant less than 1 year old

06 Patient has valid ID issued within 120 days (shown DEERS ineligible).

07 Emergency Care - Eligibility and billing determination still required.

08 Sponsor duty station outside the 50 states or with APO/FPO address.

09 Survivor of deceased sponsor - one time exception.

Figure A-1. DEERS Eligibility Override Code Picklist

Some patients are not eligible for NAS processing because they are not CHAMPUS eligible. These patients are screened out of NAS processing based upon their patient category. This will minimize unnecessary DEERS transactions. The ineligible patient categories are:

1. All categories that imply an active duty or reserve status (x11, x12, x13, x14, x15, x21, x22, x23, x26, x27, and x28).

2. All categories that start with the letters K or X.

All other PATCATS will be "sorted" into the following five. DEERS PATCATs when NAS data is transmitted to DEERS:

1.	Retired	A24	A25	A31	A32	A33		
		B24	B25	B31	B32	B33		
		C24	C25	C31	C32	C33		
		F24	F25	F31	F32	F33		
		M24	M25	M31	M32	M33		
		N24	N25	N31	N32	N33		
		P24	P25	P31	P32	P33		
2.	Dependent AD	A41	B41	C41	F41	M41	N41	P41
3.	Dependent Ret	A43	B43	C43	F43	M43	N43	P43
4.	Former Spouse	A48	A49	B48	B49	C48	C49	F48 F49
		M48	M49	N48	N49	P48	P49	
5.	Survivor	A45	A47	B45	B47	C45	C47	F45 F47
		M45	M47	N45	N47	P45	P47	

X = Any alpha character that indicates a branch of service, such as A, B, C, F, M, N or P.

Figure A-2. Patient Categories

Table A-9. Major Diagnostic Codes (MDC)

Code	Reason
01	Diseases and Disorders of the Nervous System.
02	Diseases and Disorders of the Eye.
03	Diseases and Disorders of the Ear and Throat
04	Diseases and Disorders of the Respiratory System.
05	Diseases and Disorders of the Circulatory System.
06	Diseases and Disorders of the Digestive System.
07	Diseases and Disorders of the Hepatobiliary System and Pancreas.
08	Diseases and Disorders of the Musculoskeletal System and Connective Tissue.
09	Diseases of the Skin, Subcutaneous Tissue and Breast.
10	Endocrine, Nutritional and Metabolic Diseases.
11	Diseases and Disorders of the Kidney and Urinary Tract.
12	Diseases and Disorders of the Male Reproductive System.
13	Diseases and Disorders of the Female Reproductive System.
14	Pregnancy, Childbirth and Puerperium.
15	Normal Newborns and Other Neonates with Certain Conditions.
16	Diseases and Disorders of the Blood and Blood Forming Organisms.
17	Myeloproliferative Disorders and Poorly Differentiated Neoplasms.
18	Infectious and Parasitic Diseases (Systemic or Unspecified Site).
19	Mental Diseases and Disorders.
20	Alcohol, Drug Use and Alcohol/Drug Induced Organic Disorders
21	Injuries, Poisonings, and Toxic Effect of Drugs.
22	Burns
23	Factors Influencing

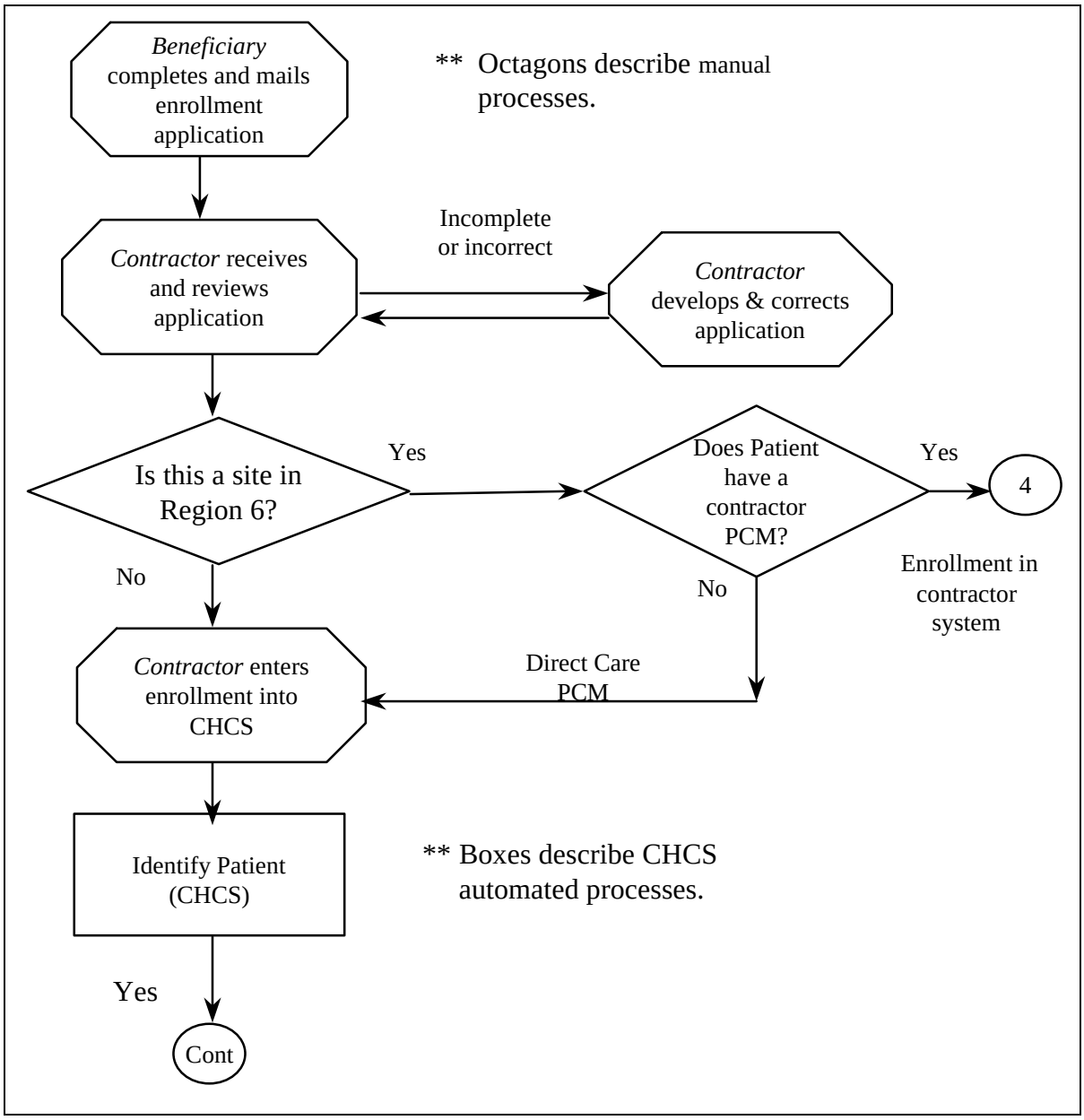

Figure A-3. CHCS Enrollment: Active Duty at All Sites and Non-Active Duty in Regions 1, 2, 5, and 6
(Sheet 1 of 6)

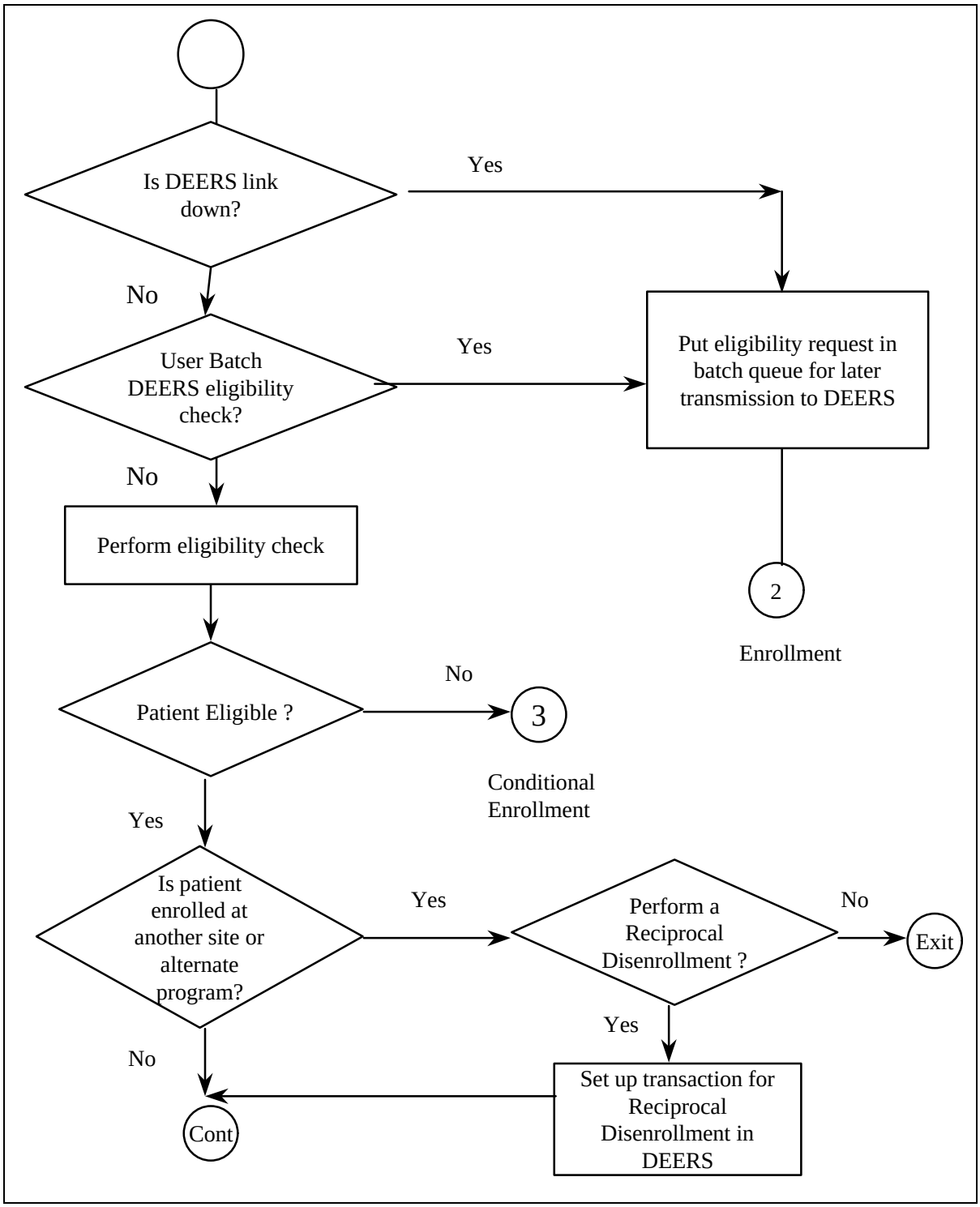

Figure A-3. CHCS Enrollment: Active Duty at All Sites and Non-Active Duty in Regions 1, 2, 5, and 6
(Sheet 2 of 6)

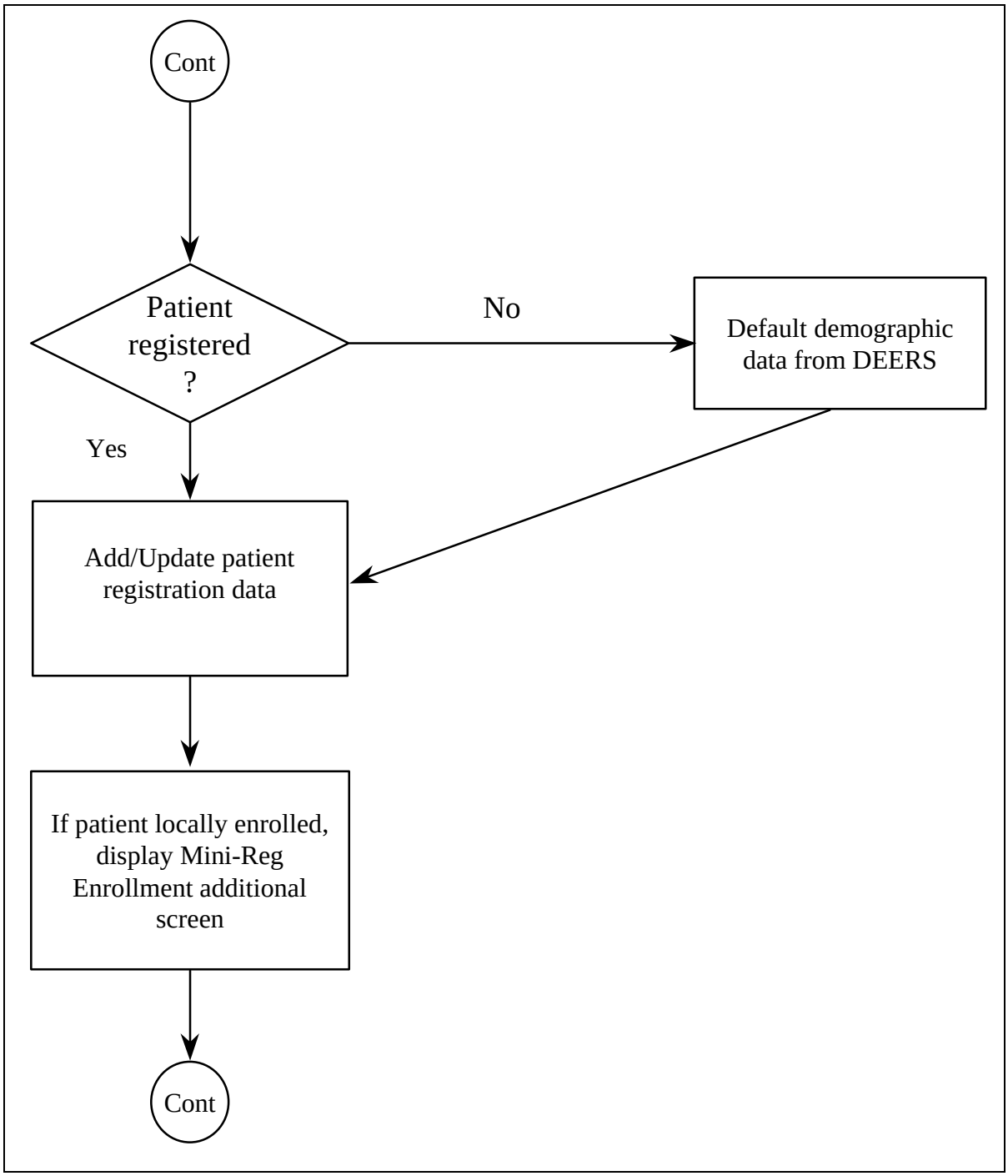

Figure A-3. CHCS Enrollment: Active Duty at All Sites and Non-Active Duty in Regions 1, 2, 5, and 6
(Sheet 3 of 6)

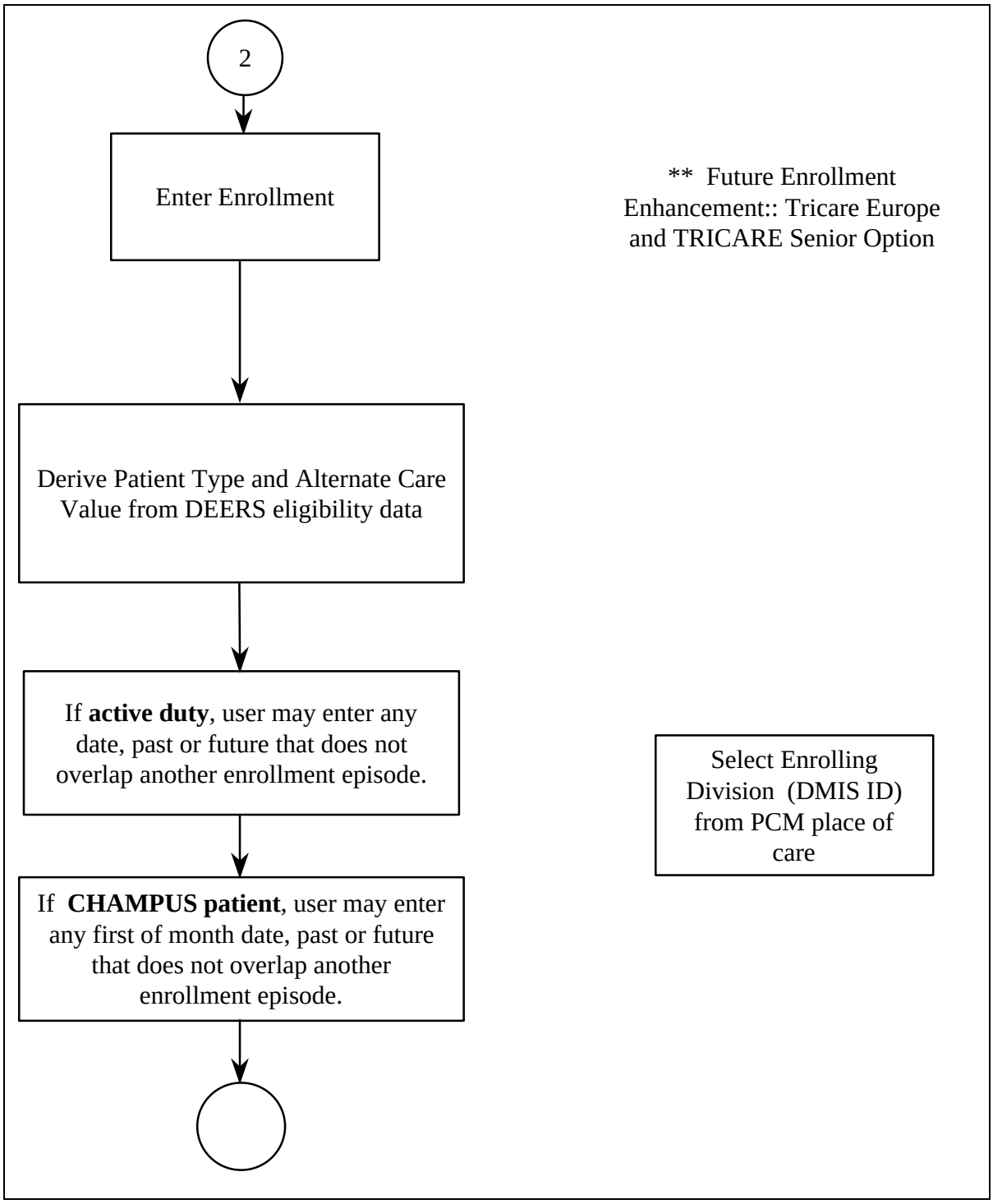

Figure A-3. CHCS Enrollment: Active Duty at All Sites and Non-Active Duty in Regions 1, 2, 5, and 6
(Sheet 4 of 6)

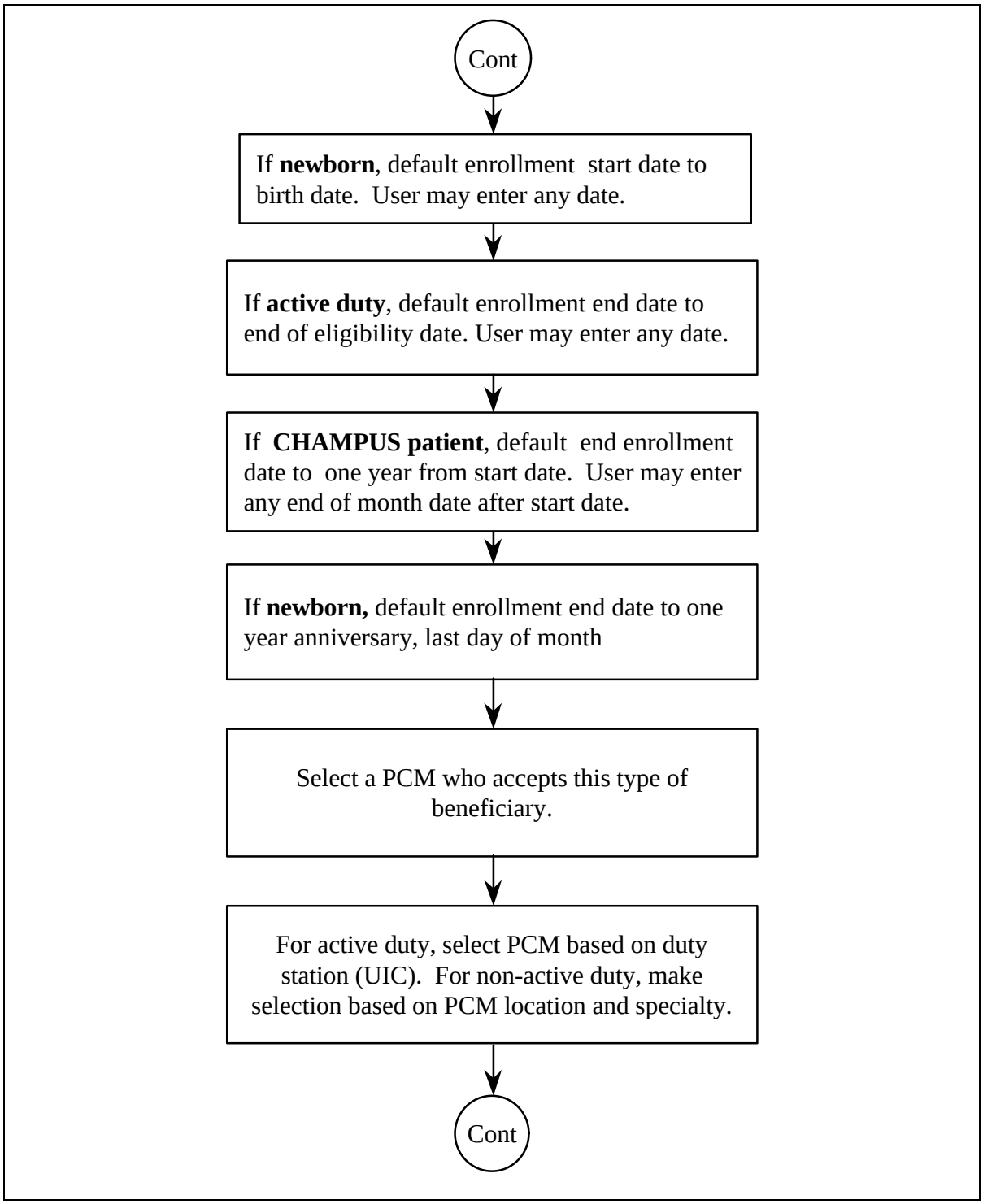

Figure A-3. CHCS Enrollment: Active Duty at All Sites and Non-Active Duty in Regions 1, 2, 5, and 6
(Sheet 5 of 6)

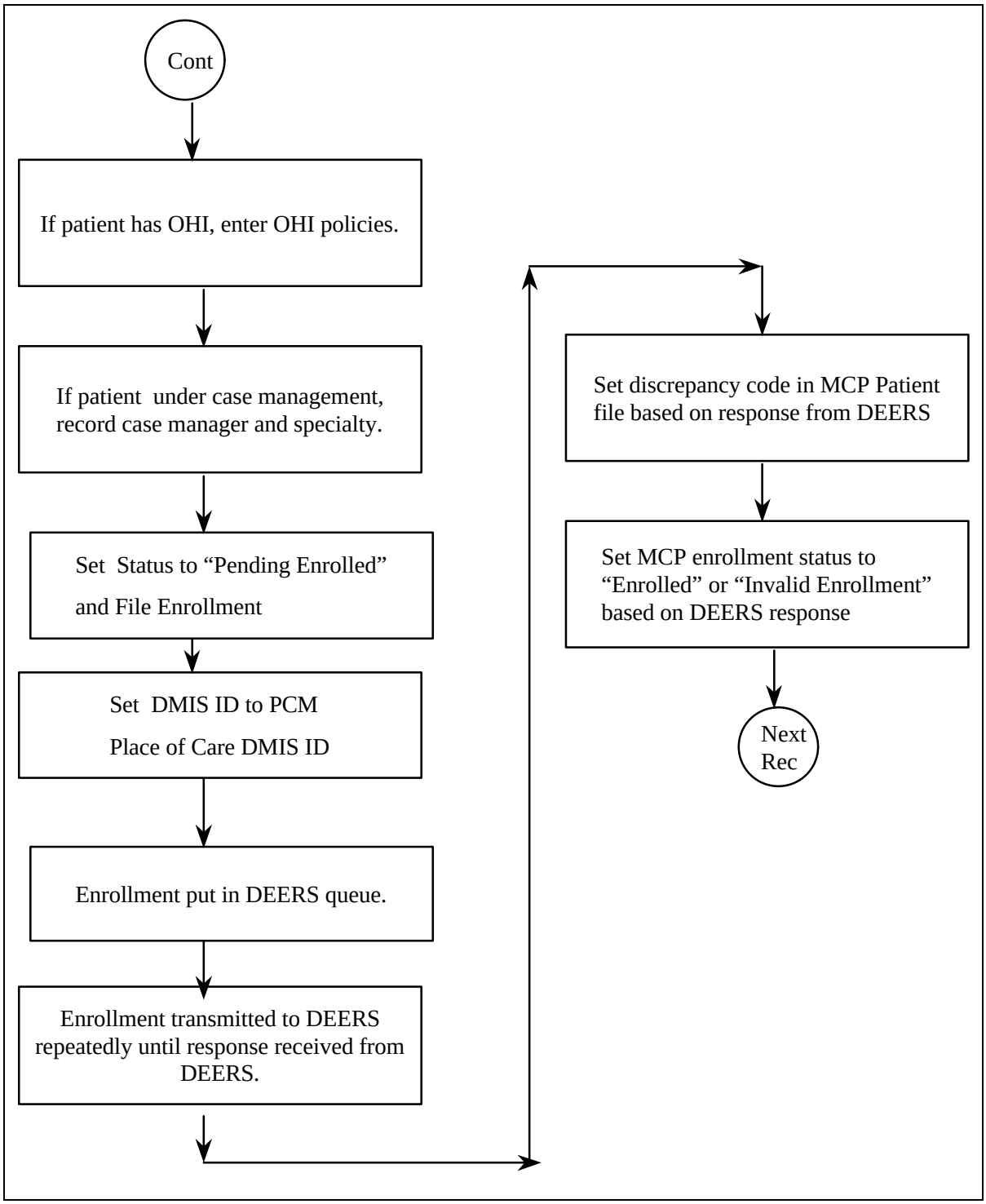

Figure A-3. CHCS Enrollment: Active Duty at All Sites and Non-Active Duty in Regions 1, 2, 5, and 6
(Sheet 6 of 6)

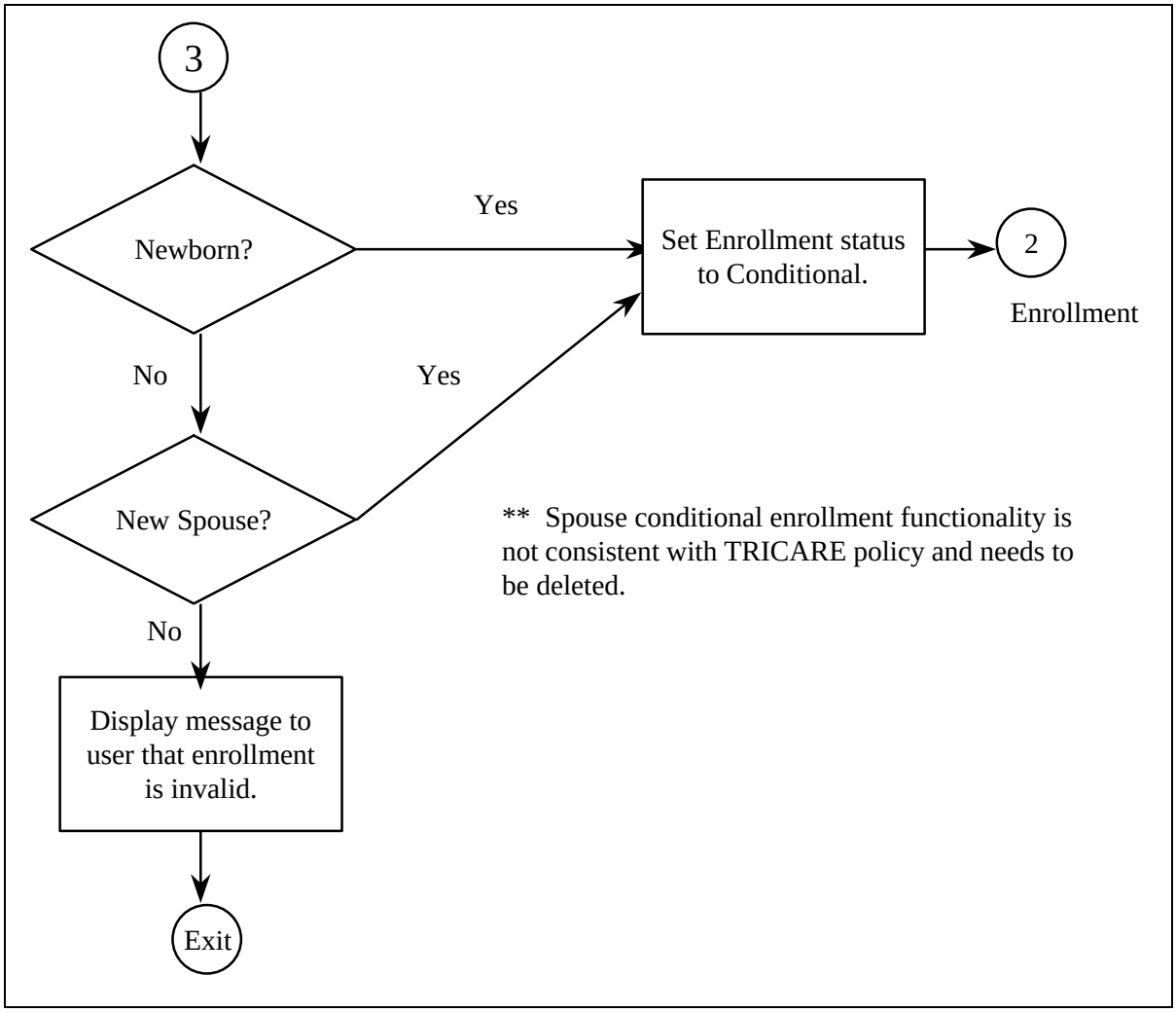

Figure A-4. CHCS Conditional Enrollment On-line Processing

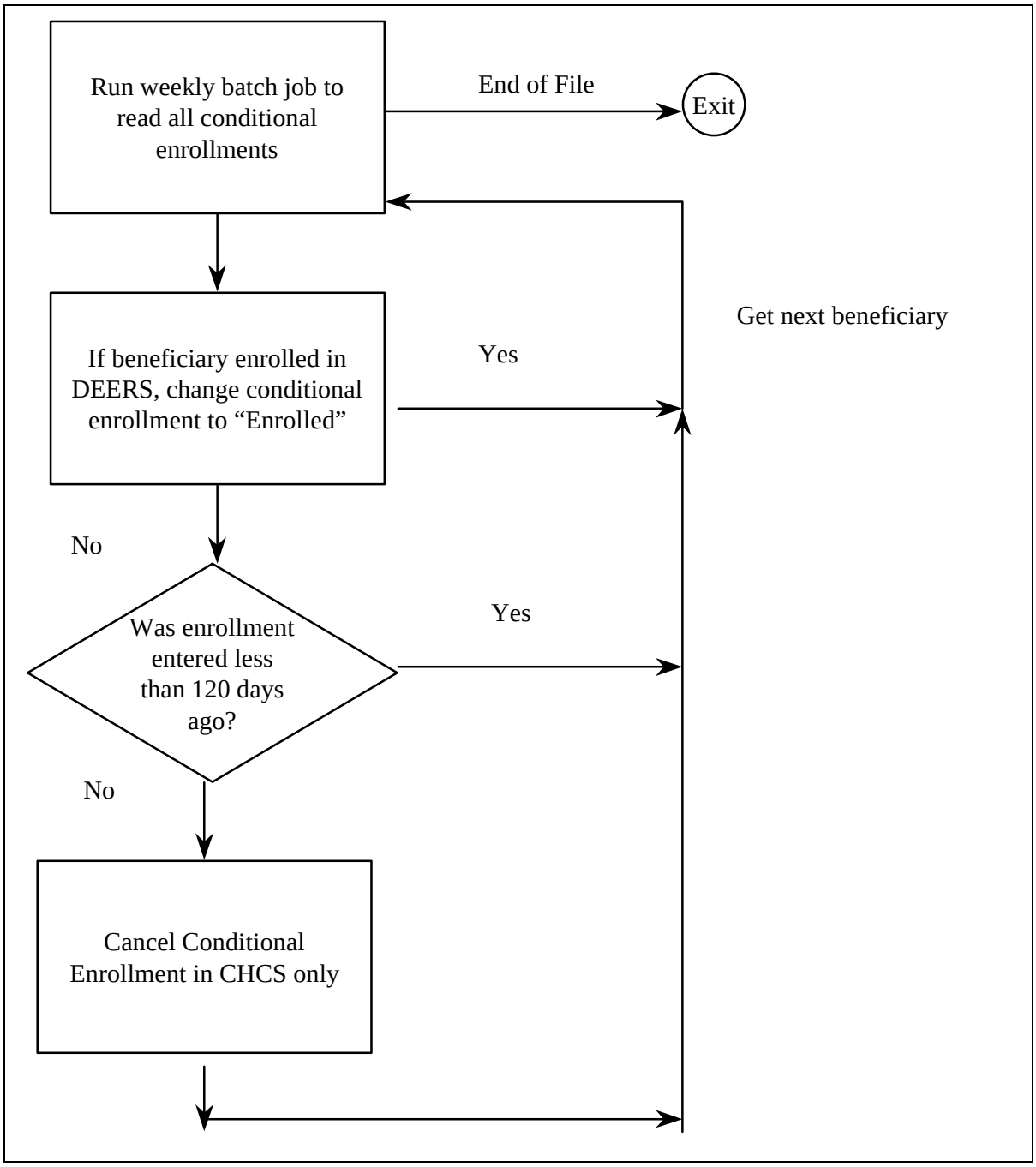

Figure A-5. CHCS Conditional Enrollment Nightly Processing

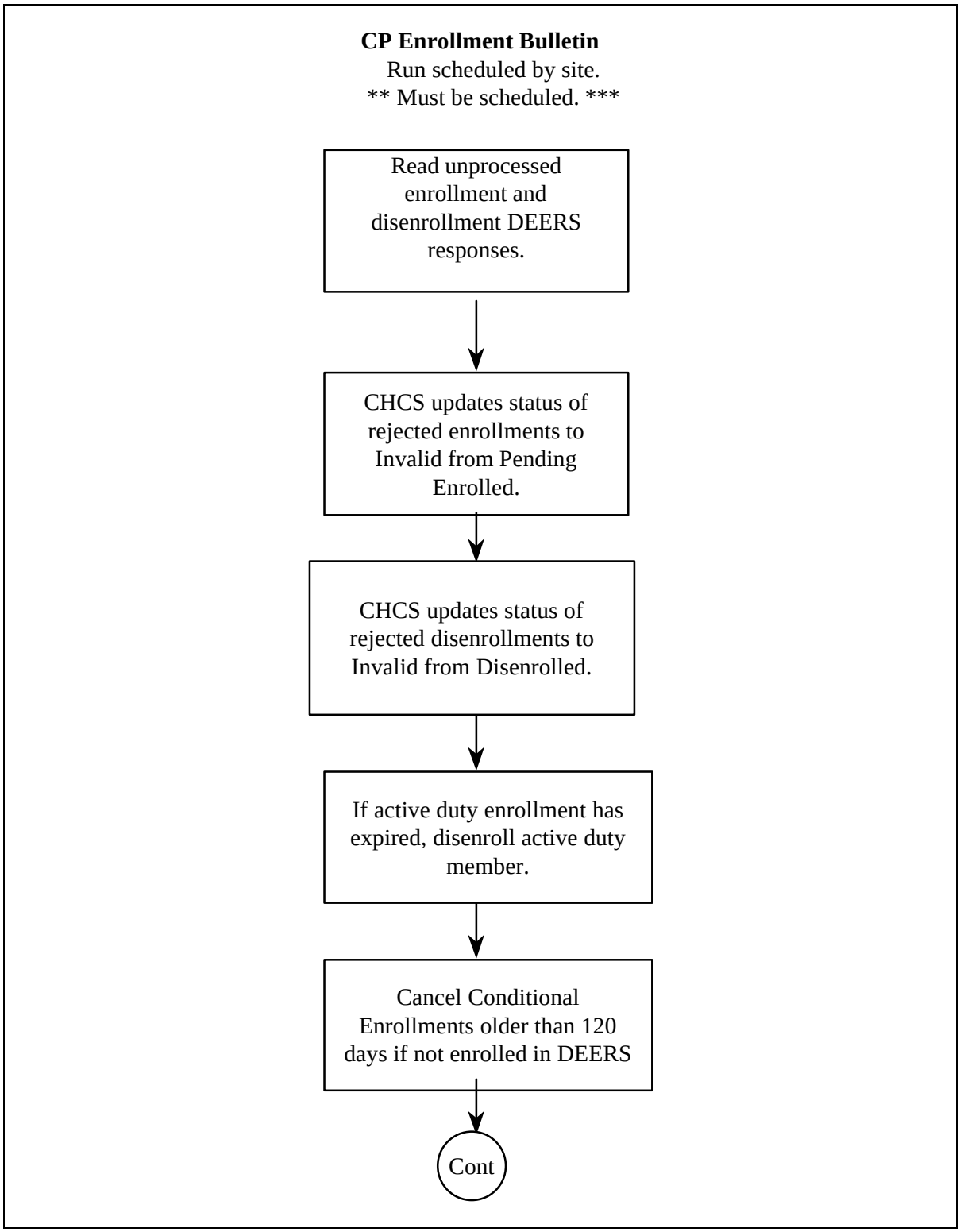

Figure A-6. CHCS Enrollment Nightly Processing

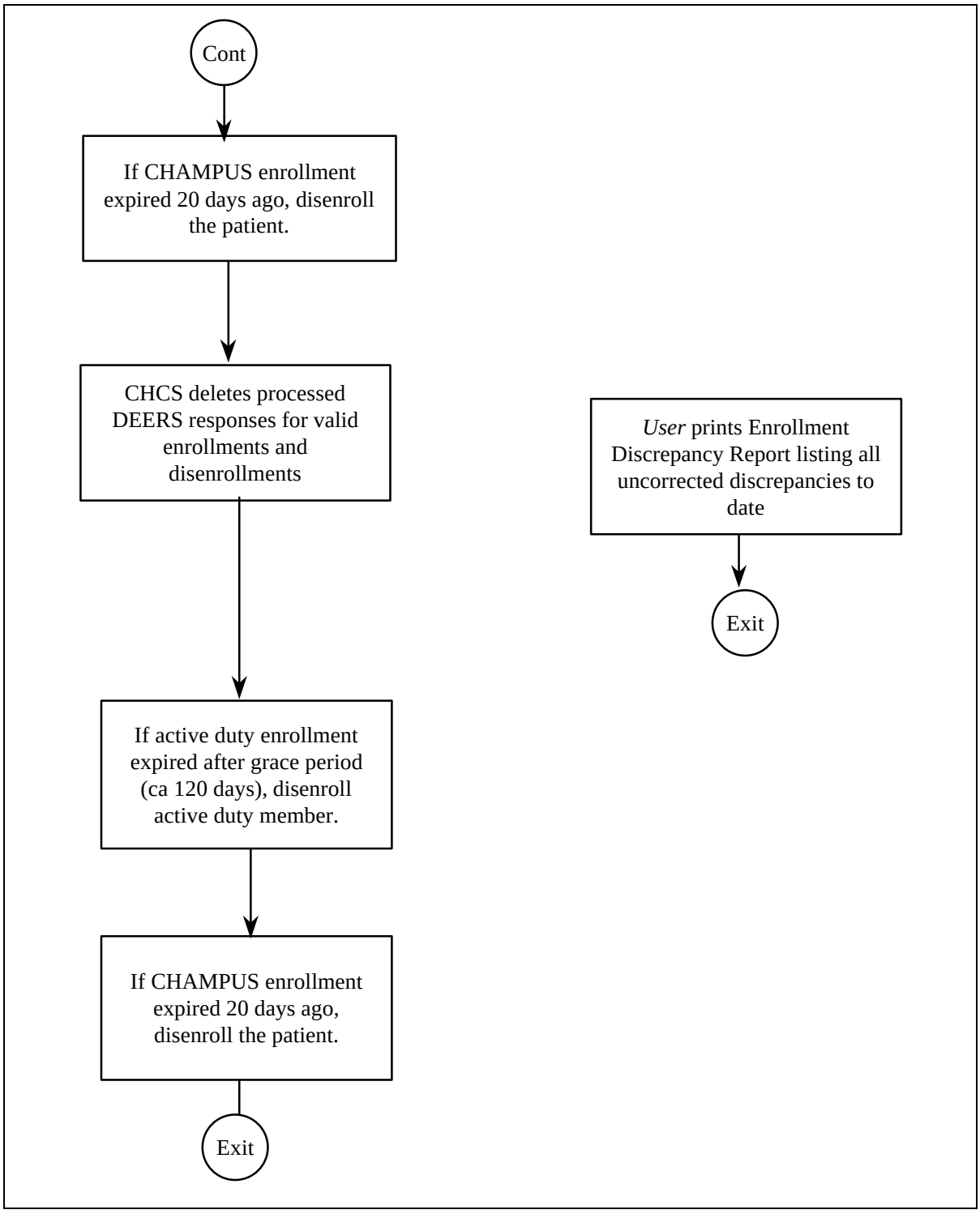

Figure A-7. CHCS Discrepancy Reporting

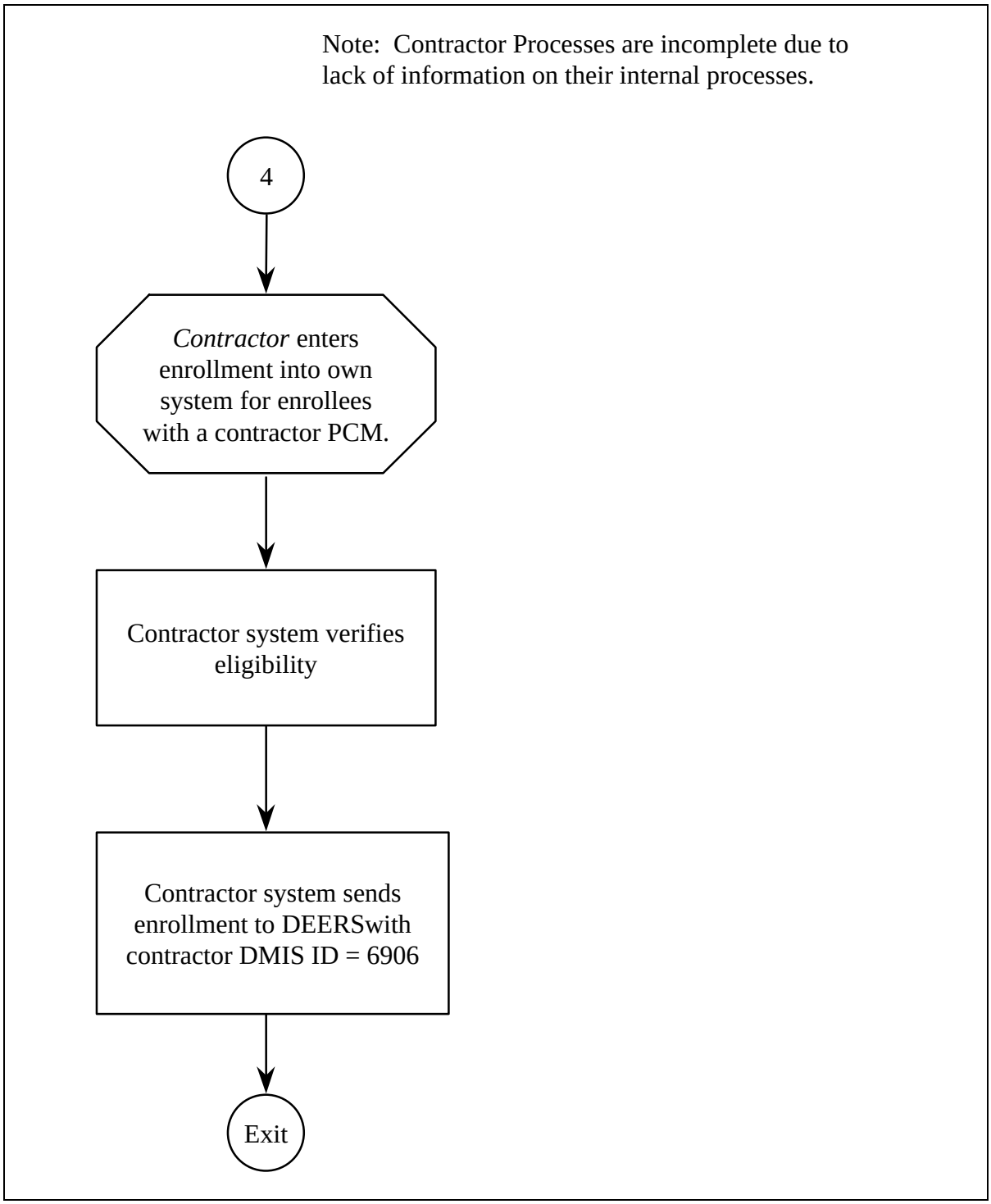

Figure A-8. Contractor Enrollment Processing Region 6

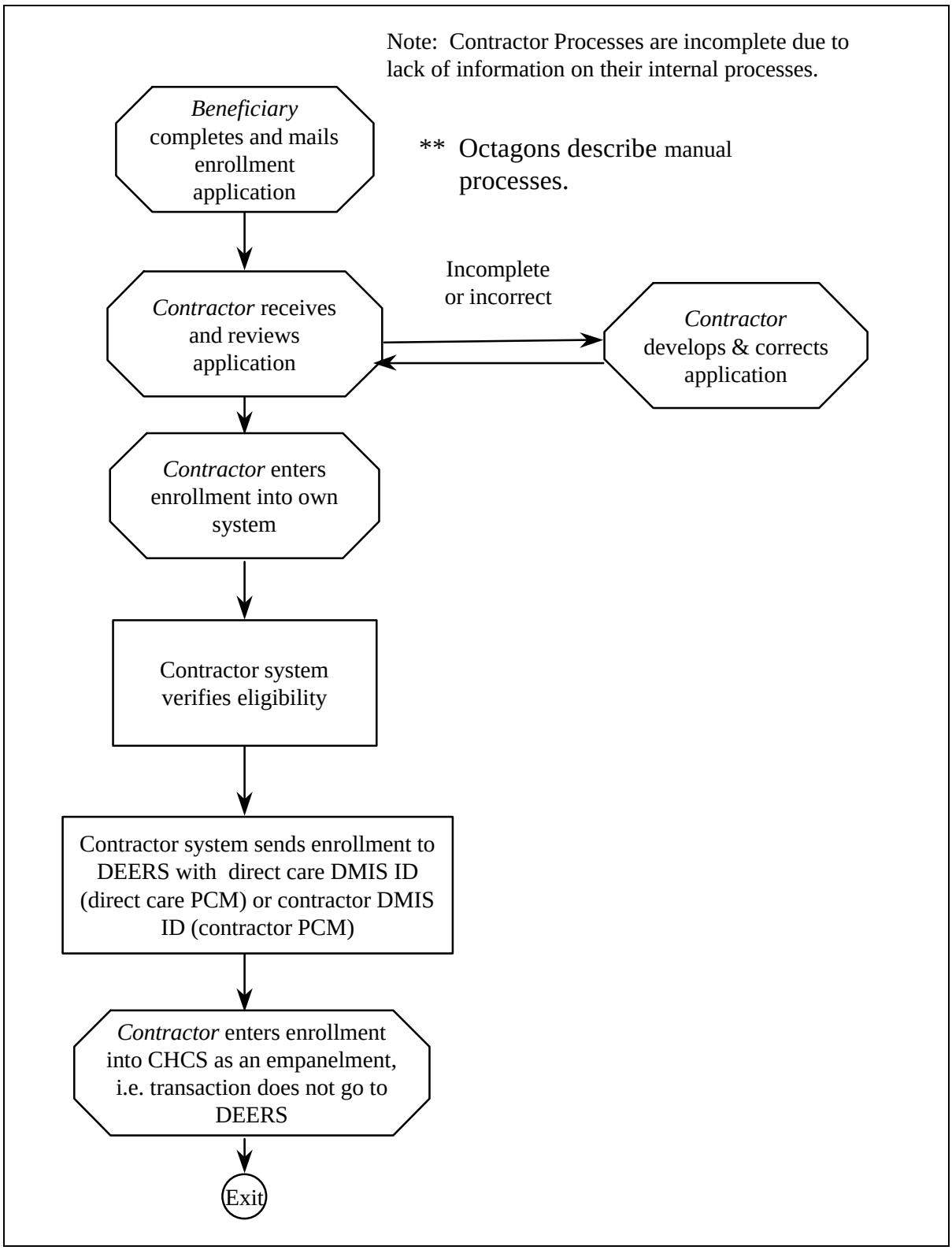

Figure A-9. Contractor Enrollment Processing Regions 3, 4, 7, and 8

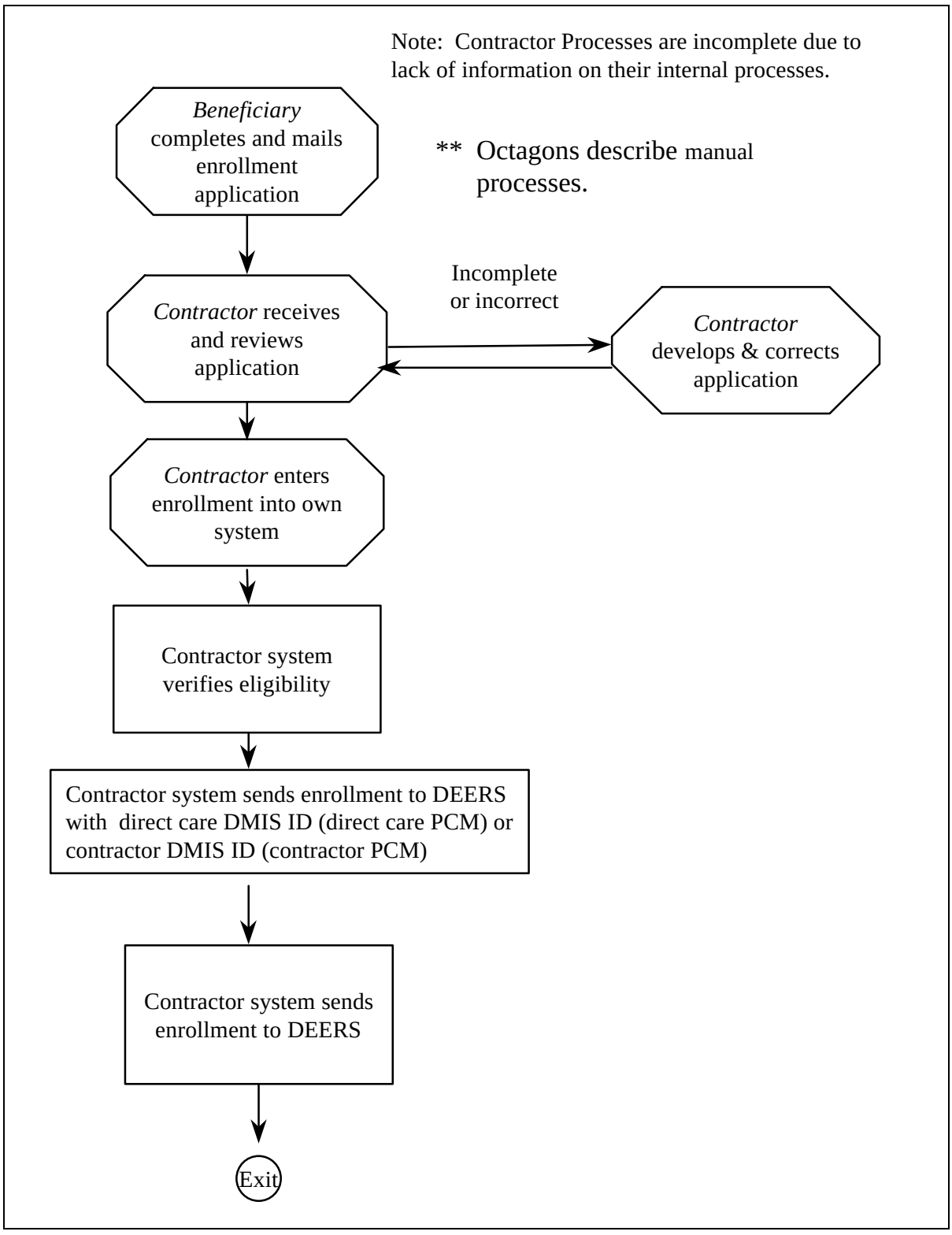

Figure A-10. Contractor Enrollment Processing Region 11

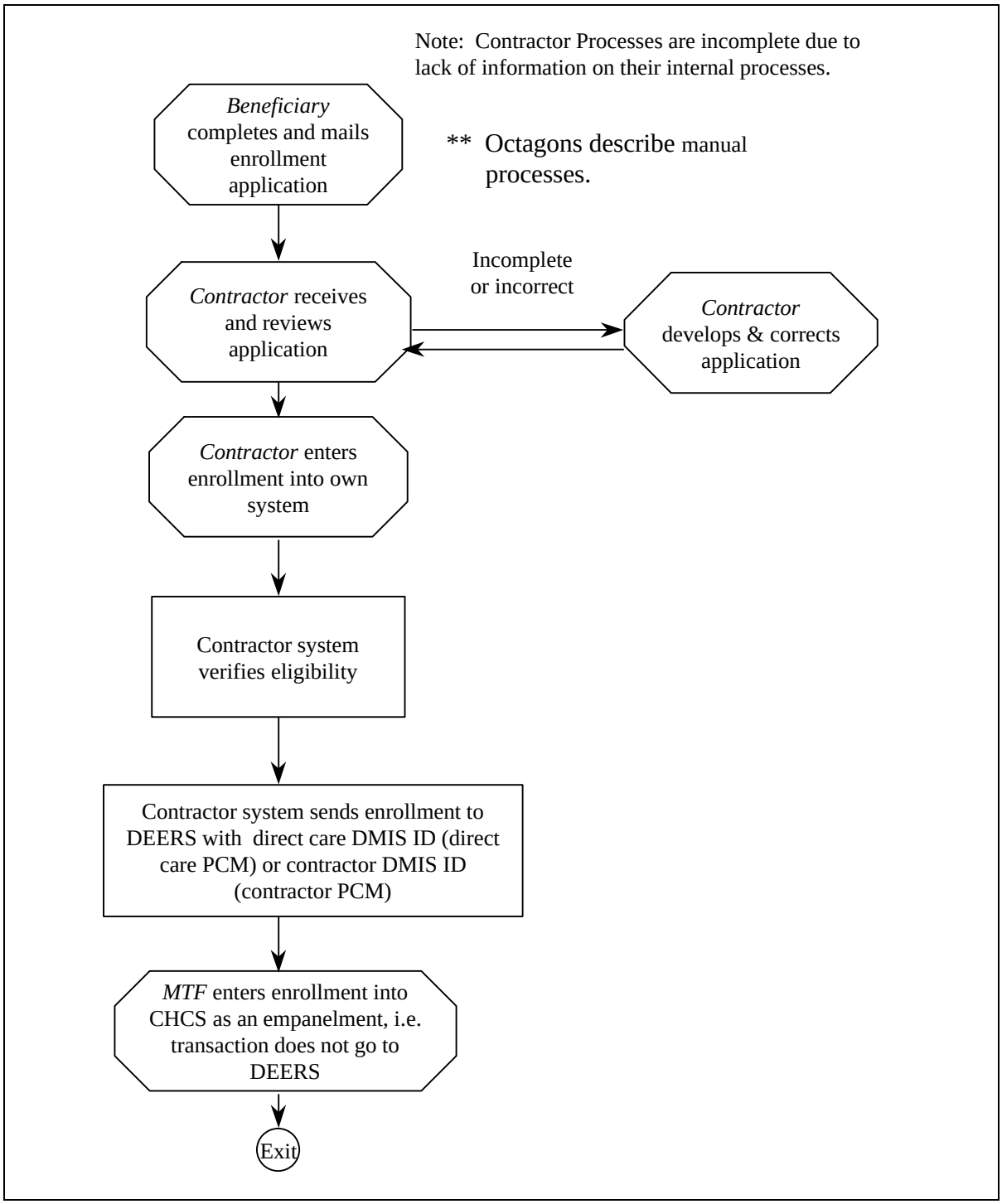

Figure A-11. Contractor Enrollment Processing Regions 9, 10, and 12

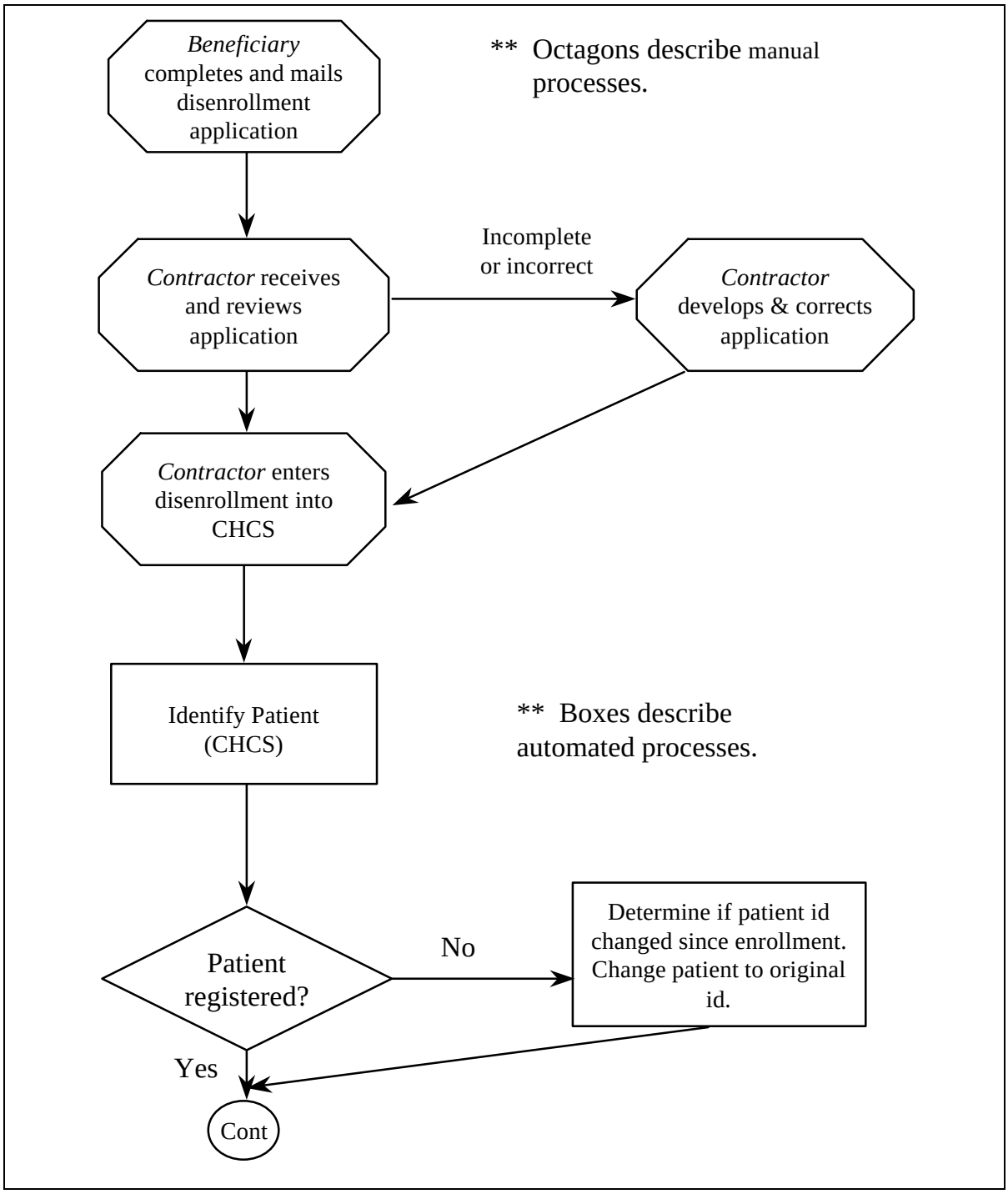

Figure A-12. CHCS Disenrollment
(Sheet 1 of 2)

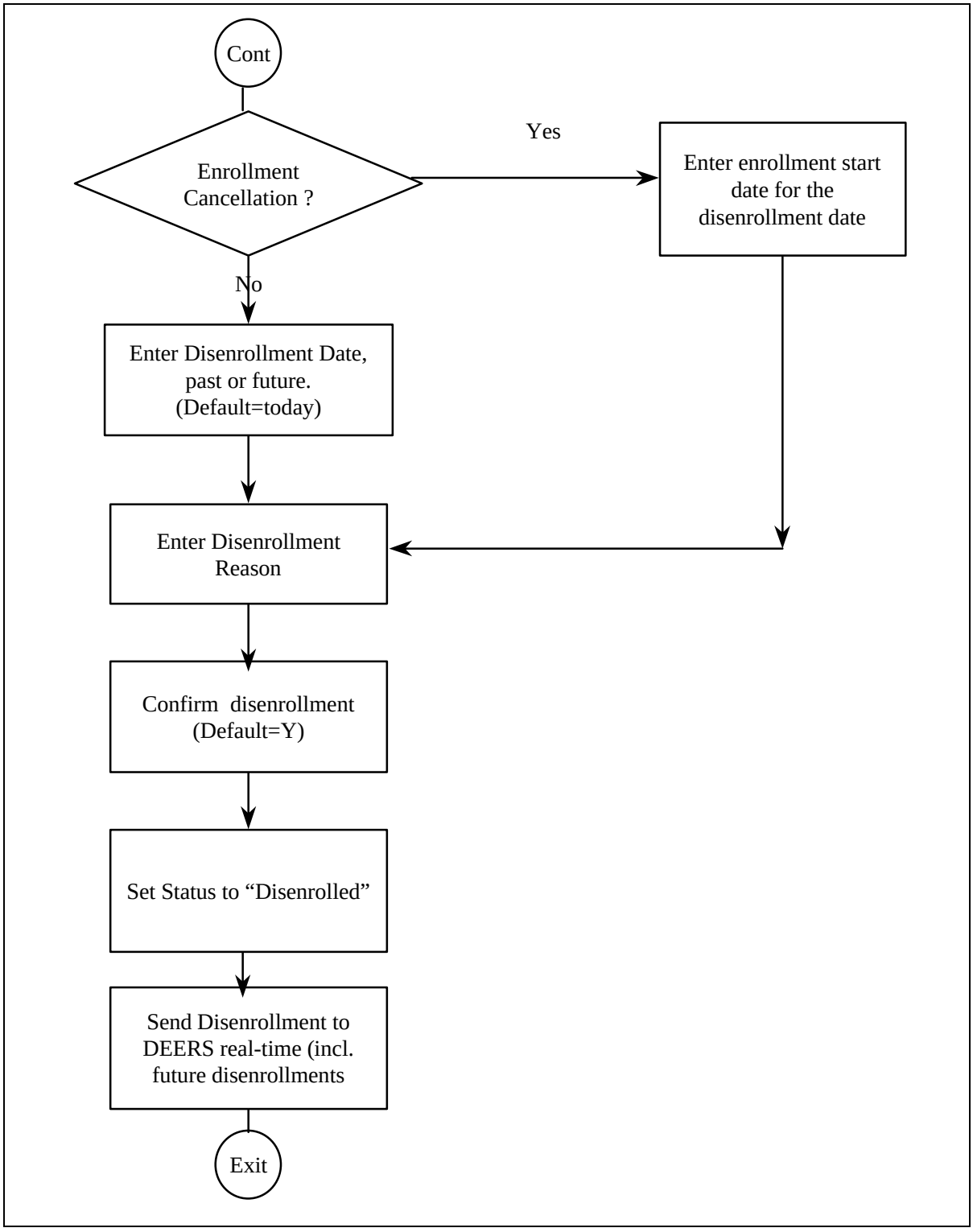

Figure A-12. CHCS Disenrollment
(Sheet 2 of 2)

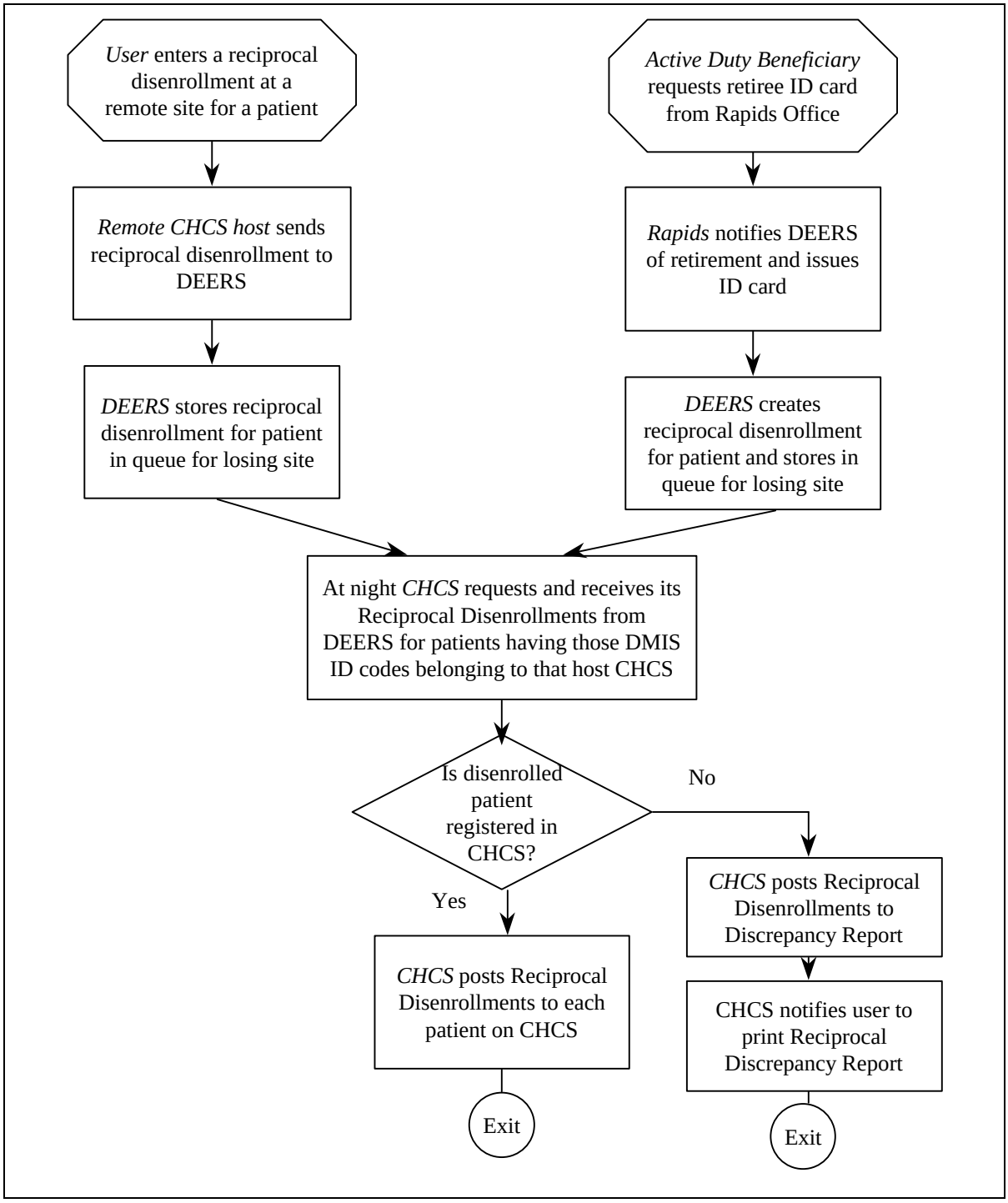

Figure A-13. CHCS Reciprocal Disenrollment

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CHCS: MCP DESKTOP USER GUIDE

Appendix B
Glossary

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Appendix B. Glossary

Term	Definition
Access	The process of requesting an entry in a particular file or in certain fields in a given file. Also refers to data security functions for files or certain fields in a file.
Access Code	See User Security.
Access/Verify Codes	The Access and Verify codes are used in the logon process to identify a legitimate user and to gain access to CHCS. Both codes are site-specific and established by the CHCS System Manager. Only the verify code may be changed by the individual user. The codes do not show on the screen when entered.
Action Bar	A horizontal bar that provides two or more functions to choose from by typing the character(s) within the parentheses and pressing <Return>. The selected function is performed and control is then returned to this action bar. (See also Smart Action Bar.)
Active Parameter	A specific value for a search criterion that the system will use to search for open schedule slots. Active parameters are displayed in the Display Window of a Search Criteria screen.
Ad Hoc Reports	Reports that consist of variable data and that are generated locally for a particular purpose or need.
Admission	The process of bringing a patient into the medical treatment facility (MTF) as an inpatient.
Alternate Care Value (ACV)	Information used by DEERS to define a patient's eligibility and enrollment plan. This information is generated by CHCS for TRICARE. A value of U indicates that the patient is enrolled in a United States Treatment Facility (USTF) and is not eligible for care in a medical treatment facility (MTF). A value of E indicated that the patient is enrolled in TRICARE PRIME.

Glossary (continued)

Term	Definition
Ancillary	Any work area that supports the care of patients on the ward or in the clinics. “Ancillary to” the ward or clinic.
Ancillary Workcenter	Those supporting workcenters targeted for automation (e.g., LAB, RAD, PAD, PHR, PAS, and DTS).
ANSI MUMPS	American National Standards Institute accepted standard for the Massachusetts General Hospital Utility Multi-Programming System (MUMPS) programming language.
Application Software	Software that runs CHCS and performs functions necessary to control or make the system work.
Appointing	Synonymous with “appointment booking” or just “booking.”
Appointment, Patient	A specific time reservation for a patient to see a specified care provider. Patients are said to have appointments; clinics and care providers are said to have schedules.
Appointment Booking	The process of searching for, selecting, and reserving an appropriate schedule slot for a specified patient booking.
Appointment Referral	A patient appointment request for specialized care generated by the primary care manager (PCM).
Appointment Search Criteria	See Search Criteria.
Appointment Slot	A single time opening in a provider's template or schedule for a certain type of appointment. The slot has a begin and end time, and the maximum number of patients that can be seen during that period. This is also referred to as a schedule time slot.
Appointment Type	A broad generic designation of the type of care to be provided during an appointment or encounter.

Glossary (continued)

Term	Definition
Appointment Type, Alternate	A secondary appointment type for a schedule slot that is not filled within a specified time (e.g., 48 hours before the appointment). Used for changing unused appointment slots into different usable slots shortly before the appointment day.
Archive/Purge	The process of storing historical patient data in the archive database (archive) while removing nonhistorical patient data from the production database (purge).
Arrival Time (Appointment)	The time patients are told to arrive for their appointments. This may or may not be different from the beginning time or booking time, which is the time at which they are actually scheduled to be seen.
At Sign (@)	1) An edit response meaning delete the current value and leave the field empty of data. 2) Used to show appointment times (e.g., 13Jun@1000).
Attribute	Information describing a file or data element. Types of attributes include data types, ranges, descriptions, and checks performed upon entry of a data element.
Authority	Having all required security keys needed to perform specified functions using CHCS.
Authorization Level (Order Entry and RAD)	In order entry and Radiology, there are five authorization levels: Clerk, Nurse, and three kinds of health care provider (HCP): **Clerk Authorization:** The system prompts clerks to provide the ordering/authorizing HCP. Clerks may only transcribe written orders. Although clerks may enter new orders, these orders do not become active until they are signed by a nurse or physician.

Glossary (continued)

Term	Definition
	Nurse Authorization: The system prompts nurses to provide the ordering/authorizing HCP and the order origin (verbal, telephone, or handwritten). The orders that nurses enter become active, but they must be signed by a physician. **HCP Authorization:** This is the standard physician authority and the highest level needed for all orders except those special procedures requiring a countersignature. Physicians are not prompted for ordering or authorizing HCP or order origin. **HCP Requiring Countersignature:** This authorization level is similar to the nurse in that countersignature is always required. This level of authorization is usually assigned to interns, physician assistants, and medical students. The orders that they enter may be signed by anyone with HCP authorization. These do not require the Countersigning HCP authorization level. **Countersigning HCP:** This level of authority allows the physician to countersign orders for special procedures. For example, this authorization level would be assigned to radiologists who need to approve certain tests and procedures.
Backspace/Delete Key	See Computer Control Keys.
Batch PCM Reassignment	Allows the reassignment of a group of enrollees in the Managed Care Program (MCP) from one primary care manager (PCM) to another without having to do individual reassignments.
Beneficiary Type	Synonymous with “patient type”
Block Booking	A processing function of the Book Appointments option, Block Booking allows the user to book multiple patients for appointments in multiple time slots.

Glossary (continued)

Term	Definition
Booking Authority	A restriction on an appointment slot that allows booking only by specified classes of appointers. For example, certain slots may be designated as being bookable only by persons with greater medical knowledge who would be assigned a higher booking authority. This is independent of, and distinct from, any other booking restrictions based on, for example, clinic (perhaps one clinic may not be allowed to book into another), or function (some users may be allowed to register patients, but not book them or may be allowed to book appointments but not to maintain schedules). Booking authority is managed via the use of site-specific security keys.
Borrower	In Record Tracking, a borrower is defined as a location, entity, or individual to whom records are loaned. This may be a physician, a hospital employee, a clinic, a ward, a hospital location, or a patient.
Browse Action (PAS)	The Browse options are used to display a provider's schedule, overbook scheduled appointment slots, or modify slots for a specific booking need. Slots can be modified by changing appointment type, splitting one slot into two slots, or joining several slots into one slot. Browse is accessed by selecting the Browse Action from either the Search Action Bar or the Appointments Action Bar when booking appointments.
Bulletin	A MailMan message sent to a mailgroup by the Postmaster or automatically by the system based on a CHCS event.
Cancellation	The process of voiding a pending appointment. There are two modes of cancellation: 1) Patient-initiated cancellation, in which the patient calls in to cancel an appointment. In this case, the

Glossary (continued)

Term	Definition
	canceled slot becomes free for another appointment. 2) Clinic-initiated cancellation, in which the health care provider (HCP) and/or clinic cancels an appointment or an entire block of appointments (or schedule slots). In this case, a list of patients with booked appointments in the schedule block is printed so that they can be contacted and informed of the cancellation. (As some sites, cancellation notices are mailed to the patients.) When a clinic cancellation occurs, the slots are no longer available for booking.
Catchment Area	A catchment area is the geographical area roughly within a 40-mile radius of a medical treatment facility (MTF).
Cathode Ray Tube (CRT)	A TV-like type of video display terminal for interacting with an online computer system. See Keyboard Video Display Terminal.
Check-In	The data entry function, whereby the facts of a completed appointment are entered into the system to "close the loop." Check-in data include primarily the indication of whether the patient did or did not keep the appointment (Show or No-Show), and which provider treated this patient.
Class Evaluation Report	Form used by CHCS presenters to document their perception of how effective the class was and what measures could be taken to make the class presentation better.
Clinic	An outpatient workcenter defined as a hospital location.
Clinical Service	A clinical specialty within a medical treatment facility (MTF).

Glossary (continued)

Term	Definition
Clinical Subsystem (CLN)	The Clinical Subsystem includes order-entry capabilities, automated due lists related to patient care activities, and results-entry capabilities. Special management activities include patient acuity, nursing care hours, nursing-specific bed management procedures, and Nursing quality assurance. The clinical subsystem's primary users include physicians, nurses, and allied health personnel.
Clinic Scheduling	The process of entering and maintaining clinic schedules. Refers also to the entire area of scheduling and entry/maintenance of clinic, care provider, facility, and profile data.
Command Security	Command security refers to Personnel Reliability Program, Presidential Support Program, and sensitive compartmented information.
Composite Health Care System (CHCS)	An integrated medical information system. CHCS facilitates the coordination of health care activities and patient information among all departments within a medical treatment facility (MTF) and its medically integrated outlying clinics.
Computer	An electronic device used to perform high-speed data processing operations and that can store the data for retrieval.
Computer-Based	A system that makes use of computer-related hardware (physical components of a computer) and software (programs that control computer operations). CHCS is computer-based.
Computer Control Keys	The following is a list of the basic computer control keys used in CHCS, and their specific location and function. **Backspace/Delete Key:** Located in the upper-right corner of the keyboard's main keypad, this key is used to delete (erase) the character to the left of the cursor.

Glossary (continued)

Term	Definition
	It is identified on the keyboard by a large left-arrow symbol containing an X. **Caret (^) Key:** Entered using <Shift>, <6> on the keyboard's main keypad, this key is used to exit the current activity. This key is not the same as an "up-arrow" key. **Cursor Control Keys:** Located to the right of the keyboard's main keypad. These keys allow the user to move between fields in Screen Mode. (These keys are also referred to as the up-arrow, down-arrow, left-arrow and right-arrow keys.) **Help:** Help text is available throughout CHCS to assist users: 1) Press ? or <Help> at menu prompts for online help. 2) Press ?? for a list of secondary menu options. 3) Press ??? for a brief description of options. 4) Press ? [option] for the OLUM text on an option. When accessing help from a field (in a prompt series on a screen): 1) Press ? or <Help> for a quick one-line help message. 2) Press ?? for extended help. 3) Press ??? to access the OLUM. **Note:** Refer to the glossary entry for the Online User Manual (OLUM). **<Hold Screen> Key:** Located on the far upper-left corner of the keyboard, in line with the function keys,

Glossary (continued)

Term	Definition
	this key is used to stop data from scrolling off the screen. Press it again to resume data scrolling. **<Lock> Key:** This key locks the alphabetical characters of the keypad into uppercase. It is located on the left side of the keyboard above the <Shift> key. A light indicates when the keyboard is "locked." A locked keyboard does not affect symbol/numeric keys. Most data should be entered in uppercase. To unlock the keyboard, just press <Lock> again. **Question Mark (?) Key:** Located on the lower right side of the keyboard's main keypad, it can be used to access CHCS Help Menu at most prompts. There are three levels of help available: – Enter ? to access the first level. – Enter ?? to access the second level. – Enter ??? to access the third level. **Note:** Refer to the glossary entry for Online User Manual. **<Return> Key:** Located on the right side of the keyboard's main keypad, it is used to tell the computer to process data just entered. **<Select> Key:** Located on the editing keypad, it is used to choose an item for editing or review. Once <Select> is pressed, an asterisk (*) appears next to the chosen item. Some selections are activated automatically, for others you must press <Return>. To deselect an item, press <Select> again. **<Shift> Key:** Located on the left and right sides of the keyboard's main keypad, these keys are used to enter individual uppercase alphabetic characters, or to enter symbols above the numeric keys.

Glossary (continued)

Term	Definition
	Spacebar: A space is entered by pressing the spacebar at the bottom of the keyboard's main keypad. **Spacebar, <Return>:** Entered by pressing the spacebar, then <Return> on the keyboard's main keypad. This sequence of keys is used to recall the most recent value entered at any Select prompt. The <Return> key must be pressed after data is entered; otherwise, the computer does not know that the response to a prompt has been given.
Cost Pool Code	These are codes used to account for expenses that cannot be directly assigned to specific services or summary accounts but are known to be associated with a selected group of services. The cost pool is a valid entry in the Medical Expense and Performance Reporting System (MEPRS) Code Table. The third character in a cost pool is always X (e.g., BCXA).
Current Appointment	An appointment that has been booked, but not yet kept. The status of such an appointment is marked by the system as “pending.” Also sometimes called a "future" appointment or a pending appointment, although these terms also have other meanings. A current appointment is not on a waiting list.
Current Procedural Terminology (CPT)	A system developed by the American Medical Association, for standardizing the terminology and coding used to describe medical services and procedures. The number affixed to the acronym represents the current version. In the Managed Care Program (MCP), these procedure and medical service codes are used to define services offered and exceptions to the overall discount schedule for Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) allowable (CA) and Usual and Customary (UC) fees.

Glossary (continued)

Term	Definition
Cursor	The flashing rectangle or underscore on the screen showing where the character is entered as the user types in responses or data.
Data	A specific value in a field for a given record. All the data for a file is stored in a data global.
Database	A collection of data organized into files fundamental to an application.
Database Management System (DBMS)	This software serves as the interface between the application programs and the database. FileMan is the CHCS database management system.
Data Element	A field within a specified file defined by specific attributes. Also, the field characteristics and the data entered in accordance with those characteristics.
Data Type	A specification associated with each field that indicates the kind of information to be entered, the format for entering information, and the way in which data is stored and retrieved. See Field. Valid data types are as follows: **Computed:** A field whose value is computed from other data. No data is actually stored in a field possessing this data type. **Date/Time:** A field that allows time data, including year, month, day, and time of day. Entries to this field are based on the system's built-in “clock”; the user may enter a partial date/time and the system will enter the remaining data. **Free Text:** A field containing any combination of alphabetic characters, numbers, and punctuation marks. The user may enter any text in the field. The characters may be limited to a minimum and/or a

Glossary (continued)

Term	Definition
	maximum, and the exact form can be specified, such as the Social Security number (SSN). **Numeric:** A field that allows only data containing numbers. **Pointer to a File:** A field that provides a reference to data in a different file to preclude the reentering of redundant data. The possible entries for this field type "point" to another file that provides choices available for response. For example, this field type may point to the states in the United States, or procedures in the Radiology Procedures file. Data entry from different prompts in different options into the pointed-to file may or may not be controlled. – **Controlled Entry:** At the prompt, the user must select from existing entries in the pointed to file. – **LAYGO (Learn As You Go) Entry:** At the prompt, the user may select from existing entries in the pointed-to file, or add to the list of entries. **Set of Codes:** A field that provides for the creation of a simple set of codes (alphabetic, numeric, or symbols) in order to input standard data choices. The possible responses to this field type are limited to a list of available entries or their abbreviations. **Word Processing:** A field that allows multiline text to be treated as a single unit, even though its data can be edited one line at time. This field type provides for word processing input, such as is required for Radiology Exam Result. The system software provides a variety of word processing editing options.

Glossary (continued)

Term	Definition
Days of Week	A search criterion where the parameter identifies specific day(s) from Monday through Sunday.
DEA Number	This is a unique number defined by the Drug Enforcement Administration (DEA) and associated with the provider. The DEA numbers have the following format: A or B followed by the first letter of the provider's last name, followed by seven digits (e.g., AZ7654321). This number, if assigned, should be inserted in the DEA number field of the provider profile.
Default	This is the text provided by the system in response to a field or prompt. A default allows entry of the most commonly used answer or the most recently inserted field value, with only one keystroke; that is, you press <Return> to accept the default.
Default Division	The division accessed by the user at logon.
Default Response	An expected response of the most common answer to a prompt. The default response may be provided by FileMan or defined by the user to save keystrokes and is followed by two slashes (//).
Default Search Criteria	The search criteria identified by a user as that user's default criteria selections, that is, the criteria for which the user wishes to change parameters continually. Default Search Criteria retain their select marks so the user does not have to reselect them.
Default View Basket	This option allows you to choose the MailMan basket into which the View Text messages are sent. If you do not indicate a basket, the View Text messages are sent to your IN basket. It is suggested that you create a mail basket (called View Text or some similar name) and specify it as your default view basket. This will keep your IN basket from being cluttered with view text.

Glossary (continued)

Term	Definition
Disenrollment Defense Enrollment Eligibility Reporting System (DEERS)	A Department of Defense (DOD) program for determining and ensuring the eligibility of potential patients for military health care.
Defense Medical Information System (DMIS-ID)	The Expense Assignment System (EAS) uses each division's DMIS-ID to define how workload is sorted and reported. Each division has a unique DMIS-ID and a parent DMIS-ID. The parent DMIS-ID defines divisions that combine their workload. The group DMIS-ID contains the DMIS-ID code of the parent organization to whom its underlying units and divisions report and rollup their workload.
Dietetics Subsystem (DTS)	The DTS Subsystem provides dietetics personnel with access to patient demographic and clinical information, and provides other system users with a mechanism for communicating diet orders and diet consults to the Dietetics Department.
Directory Setup Screen	The screen that displays the various setups for the VT320. It is used to access all other setup screens.
Display	In CHCS documentation, this heading refers to the display of a menu or a screen of information, as opposed to a prompt or a message.
Display Window	In Patient Appointment and Scheduling (PAS), the top section of the Search Criteria screen. Active search parameters are displayed in this window.
Disposition	The end point of a patient's hospitalization (inpatient episode). There are numerous disposition types, i.e., discharge, death, or the patient's leaving against medical advice.
Duplicate Patient	Two patient data records that actually belong to the same patient, or a patient registered twice in the system.

Glossary (continued)

Term	Definition
Emergency Contact	Person to contact in case of patient emergency.
Emergency Encounter Form	See SF558.
Encounter	There are two types of encounters: 1) A visit by a patient to an outpatient clinic. 2) All data related to an outpatient visit.
End-of-Day Processing	The update of patient appointment data for an outpatient clinic on a specified day. Patient appointment data includes, but is not limited to, appointment status and type, provider, clinic, and checked-in (date and time).
Entry	A data value within a field, record, or file.
Environment	The place in the computer in which the user is working, and its characteristics.
Episode	All data related to an inpatient visit, starting with admission and continuing through disposition.
EVE Menu	Also called the Systems Manager Menu, this is the very first menu that will appear after logon. This menu is the parent of all other CHCS menus.
External Provider	A non-network provider who is a member of a provider network; who has the CON,NET,PEX, or SUP agreement types; and who has a location type of Other.
Facility	See Medical Treatment Facility.
Family Booking	Appointments in multiple clinics for multiple related or unrelated patients.
Family Member Prefix	A two-digit code that identifies a patient's

Glossary (continued)

Term	Definition
(FMP)	relationship to the sponsor (e.g., son, daughter, spouse, dependent parent, etc.). FMPs are as follows: 01-19 = 1st through 19th child; 20 = sponsor; 30 = spouse; 40 = mother of sponsor; 45 = father of sponsor; 50 = mother-in-law; 55 = father-in-law; 60 = 1st other eligible dependent; 61 = 2nd other eligible dependent; 98 = civilian emergency; 99 = other.
Field	1) The space in a record used to define a data element. A field has attributes, such as a data type, storage location, and label. Data element and field are often used interchangeably. 2) A labeled area within a screen in which the user may enter and edit text.
File	1) A grouping of items with a single functional purpose. Patient information is stored in the Patient file. Ward locations, clinics, and all other hospital locations are stored in the Hospital Location file. 2) As in “to file,” used in Screen Mode when data is stored.
File Manager (FileMan)	The database management system (DBMS) used in CHCS. A general-purpose DBMS based on the Massachusetts General Hospital Utility Multi-Programming (MUMPS) programming language used to create and maintain files.
Free Text	See Data Type.

Glossary (continued)

Term	Definition
Frequency	1) This term is used to refer to how often a medication is given (e.g., Q6H, or given with a frequency of every 6 hours). 2) The estimated hours, listed on the particular intravenous (IV) bottle, that the IV will run.
Frozen Schedule Slot	A schedule slot on hold. Frozen slots will not display during appointment booking. These slots are temporarily frozen and are either released manually by the user, or automatically by the system on a user-specified date.
General Set-Up Screen	The screen used to set up the general user preference features of the VT320 terminal.
Grace Period	The time period after an enrollment has expired where the beneficiary is still eligible for care while the system verifies enrollment renewal. The grace period for beneficiaries with an ACV value of "A" is determined by the grace period parameter setting (**Menu Path:** PAS System Menu → FMCP → FTAB → PARA). The default setting is 120 days. The grace period is 20 days for beneficiaries with an ACV value of "E."
Grace Period Enrollees	Beneficiaries with expired end dates within the grace period. These beneficiaries are counted as enrolled on enrollment-related reports. The grace period for beneficiaries with an ACV value of "A" is determined by the grace period parameter setting (**Menu Path:** PAS System Menu → M → FMCP → FTAB → PARA). The default setting is 120 days. The grace period is 20 days for beneficiaries with an ACV value of "E".
Health Care Finder (HCF)	A clerk who uses the Managed Care Program (MCP) to book appointments for enrolled patients with their primary care managers (PCMs), add/modify appointment referrals for enrolled and non-enrolled patients, book appointments with network providers for non-enrolled patients, cancel and reschedule

Glossary (continued)

Term	Definition
	appointments, and generate membership identification cards, care authorization forms, and patient/provider mailing labels.
Health Care Provider (HCP)	The specific member of the health care team providing health services to the patient. Usually, this is a physician; however, the HCP may be a nurse practitioner, dentist, physical therapist, clinical dietitian, etc. HCP is not used in reference to nurses, who represent a special category in themselves. An HCP is someone who has the authority to construct patient orders for entry into the system. See Provider Class.
Health Record	Outpatient medical record.
Historical Data	Information that is considered to be relevant for direct patient care and is removed from the production database and stored in the archive database.
<Hold Screen> Key	See Computer Control Keys.
Home	The device name used to specify output to the screen.
Home Location	In Record Tracking, the place of residence for a medical record or film jacket (X-ray file) when it is not being borrowed. This home location is usually a file room.
Identifier	The fields that are displayed when selecting an entry in order to aid in the unique identification of the record to be selected.
Inactive	See Order Status.
Initialization (INIT)	The act of starting up a system.
Insert Mode	As text is entered where text exists, the entered characters are inserted at the cursor position, pushing existing text to the right.

Glossary (continued)

Term	Definition
Interact Window	In Patient Appointment and Scheduling (PAS), the bottom section of the Search Criteria screen. Messages, prompts, and action bars appear in this window.
Internal Entry Number (IEN)	A unique number assigned to each file. It is used internally in the software to identify specific records within a file.
John (Jane) Doe	A male (female) patient whose identity is unknown.
Keyboard	A typewriter-like instrument used to enter information to be sent to the computer.
Keyboard Set-Up Screen	The screen used to set up the keyboard characteristics, such as keyclick and bells.
Keyboard Video Display Terminal (KVDT)	A terminal complex that includes a keyboard and a video display. See CRT.
Laboratory Subsystem of CHCS (LAB)	The software programs that process orders for lab tests; specifically, the programs that allow the user to log in specimens, to track order status, to enter and certify results, to maintain lab files, and to generate lab reports.
Learn As You Go (LAYGO)	The process of adding records to a file through data entry into other file(s). When a field is defined as a pointer, the creator indicates whether the user is allowed to enter new data into the pointed-to file. Without LAYGO, the user must select from existing entries in the pointed-to file. With LAYGO, the user may enter new records into the pointed-to file. See Field.
Local Empanelment	Process used to conduct managed care activities on a local level, without changing the Alternate Care Value (ACV) of the non-active duty beneficiaries on the DEERS database.

Glossary (continued)

Term	Definition
Login	A process that records that a sample was received in the lab for testing.
Logoff	The user process to end a CHCS session. Three logoff choices are available: **Halt:** Allows the user to log off from any menu prompt. **Restart:** Allows the user to return directly to the Access Code prompt. **Continue:** Allows the user to end the session with the system remembering the user's location in the system. Allows the user to directly return to that system location when logging on again.
Logon	The user process to gain access to the CHCS system and begin a CHCS session.
Lookup	The process of selecting one particular entry or record from a file.
Mail Basket	Electronic file folder where the user can save MailMan mail messages. All MailMan messages are received in the IN mail basket.
Mail Box	The user file to which MailMan messages are addressed.
Mailers	Mailed notices of canceled or missed appointments. There are five different types of mailers available: Cancel Notifications, No-Show Notices, Strong No-Show Notice, Wait List, and Reminder Notices.
Mailgroup	A group of MailMan users, set up by the Postmaster, to which the user can address messages.
Mail Manager (MailMan)	The online electronic mail system of CHCS.

Glossary (continued)

Term	Definition
Managed Care Program (MCP)	A software program designed to assist military treatment facilities in the local management of Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) funds. MCP provides the capability to profile both military and civilian providers in terms of the type of medical care offered and the costs associated with the care. The software also provides the ability to enroll beneficiaries and assign a primary care manager (PCM). Referral and booking options provide the capability to record patient care needs, search for providers, book appointments, and issue care authorizations.
MCP Agreement	A provider's agreement with the government, stating the medical care to be provided to eligible beneficiaries at a negotiated rate.
MCP Enrollment	The act of enrolling a beneficiary into the Managed Care Program.
MCP Patient Type	Classifications are MCP/Active Duty, MCP/Non CHAMPUS Eligible, MCP CHAMPUS.
MCP Status	Used to determine a patient's enrollment status within the Managed Care Program (MCP). Statuses are as follows: **Enrolled**: A patient is currently enrolled in the MCP. **Invalid Enrollment**: A discrepancy response is received from Defense Enrollment Eligibility Reporting System (DEERS) as a result of filing a patient's enrollment into the MCP. **Conditional Enrollment**: An ineligible response is received from DEERS when enrolling a dependent patient who is not registered on DEERS; however, if the patient's sponsor is DEERS-registered and the ineligibility is overridden, the MCP status is displayed as Conditional Enrollment.

Glossary (continued)

Term	Definition
	Pending Enrollment: A response from DEERS was delayed (for example, if the DEERS line is busy and the inquiry must be batched) during patient enrollment, or the MCP enrollment date is a future date. **Disenrolled**: A patient formerly enrolled in the MCP is no longer enrolled. **Invalid Disenrollment**: A discrepancy response is received from DEERS after sending a Disenrollment transaction. **Blank**: A patient has no enrollment history in the MCP.
Medical Expense and Performance Reporting System (MEPRS)	The Medical Expense and Performance Reporting System for fixed military medical and dental treatment facilities. MEPRS provides consistent principles, standards, policies, definitions, and requirements for accounting and reporting of expense, manpower, and performance by Department of Defense (DOD) fixed medical facilities.
Medical Record	The physical record of a patient's care containing printed (paper) copies of the documents detailing the patient's treatment in either inpatient or outpatient settings.
Medical Treatment Facility (MTF)	A military hospital and its outlying affiliated workcenters. Also called Facility.
Menu	A list of options (choices) presented by the software that represents a decision point in the running of the program. The menus available to individual users are determined when the CHCS system manager sets up the User Record. **Secondary Menu:** A list of system options available when you enter ??.

Glossary (continued)

Term	Definition
	CHCS Orientation Menu: A special menu designed to support Orientation classes. **Menu Management:** A CHCS tool that is used to maintain menus, options, security keys, and help text.
MEPRS Code	A four-character alpha code used to identify cost centers at the medical treatment facility (MTF). The MEPRS code is used for workload accounting purposes. These codes are assigned to each transaction to track who ordered the transaction and to calculate workloads. MEPRS codes at the 4th level are unique at the CHCS Group/Division Level and consist of three Department of Defense (DOD) standard characters to identify the service provided and a unique fourth character assigned by the MTF.
Message	1) Short for system message. It means information supplied by the system in response to user input, for example, ** END OF REPORT **. 2) When used with MailMan, message means an electronic note that has been transmitted.
Mini Registration	An abbreviated patient registration function. A series of screens used to create or update a basic patient record.
Mnemonic	A device designed to aid recall; for example, the menu synonyms used in the CHCS menu selection, such as ORE for Order Entry or BOK for Book Appointments.
Monitor	The part of the terminal containing the screen. Also called a visual display terminal (VDT) or visual display unit (VDU). (See Screen.)
MTF-Specified/Defined	A parameter specified at the division level in a multidivisional medical treatment facility (MTF) or at

Glossary (continued)

Term	Definition
	the MTF level if there is only a single division. This neither requires nor precludes that there be a specification at both the medical treatment facility (MTF) and division level.
MTF-Specified Time Period	A period of time determined by each medical treatment facility (MTF) that may be modified periodically.
Multiple Clinic Booking	Several appointments in multiple clinics for one patient.
Multiple Field	Often simply called a multiple, it is a field that can have more than one unique value. In effect, a multiple is a minirecord within a record. An indicator of a multiple is the Select prompt.
NAS Issuing Officer	The military medical commander or designee who is authorized to issue non-availability statements (NASs).
Network Provider	These are individual providers, organized as part of provider groups or institutions, that have an agreement with the medical treatment facility (MTF) to provide services at a discount rate to Managed Care Program (MCP) enrolled beneficiaries or to non-enrolled beneficiaries as part of a Preferred Provider Organization (PPO). The PPO may benefit non-enrolled patients, since non-enrolled patients may be booked to an MCP provider who charges less than Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).
Nonhistorical Data	Information that is no longer vital to patient-specific medical care and is purged or erased from the production database.
Non-Network Provider	Only Service Available or Exception providers with an agreement type of NON and a location type of Other.

Glossary (continued)

Term	Definition
	Individual providers (which may be organized as provider groups or institutions) with whom the medical treatment facility (MTF) does not have an agreement to provide services to eligible beneficiaries at a discounted rate.
Nonsearchable Schedule Slot	A schedule slot into which patients Schedule Slot cannot be booked. The system automatically appends a nonsearchable appointment type with an asterisk (*), and these slots become place holders only in a provider's schedule. Examples of nonsearchable slots are lunch, meeting, TDY, rounds, etc.
Online Users Manual (OLUM)	The OLUM consists of the user instructions for the CHCS basic system, MailMan, ad hoc reporting options of FileMan, and each subsystem. Each subsystem volume provides the menu hierarchy, functional description for each option, step-by-step user instructions, and samples of screens and reports. 1) Enter **OLUM** at the Secondary Menu or any menu/option selection prompt to get to the OLUM Menu. 2) Enter **?OPTION NAME** at menu/option selection prompt (only where the menu/option is displayed) to go directly to the option description in the OLUM. 3) Enter **???** after enter/edit prompt within any option to go directly to the option description in the OLUM.
Option	One of a list of processes on a menu that allows the user to access data in a file or to access another menu.
Order	A request for procedure, service or item to be performed or delivered.

Glossary (continued)

Term	Definition
Order Status	Indicates an order's current level of execution: **Active:** An order that is current and available for workcenter and/or ancillary processing. **Countersignature Due:** A previously signed order to which a countersignature must be added to confirm and activate the order. **Expiring:** An order that will soon be no longer active, contingent upon the duration of the order. **HCP Signature Due:** An order that requires a physician's verification or signature. **Inactive:** An order that is not being executed at the present time. **Modified:** An order partially activated at patient arrival. **Nurse Signature Due:** An order that requires a nurse's verification or signature. **On Hold:** An order suspended until reactivation (e.g., preadmission orders remain on hold until altered). **Pending:** An active order awaiting further action (e.g., pending appointments). **Pending Appointment:** An order awaiting appointment scheduling from another subsystem. (This is different than Pending Appointment in PAS.) **Preactive:** An order that has not been activated; user is still entering orders for his batch.
Outpatient Encounter Form	See SF600I.

Glossary (continued)

Term	Definition
Overbook	To book more patients in a schedule slot than was allocated when the schedule was created. An overbooked schedule slot has more booked patients than the maximum number of patients per slot set for the slot when the schedule was created.
Panel	1) In the Laboratory Subsystem, a group of related tests with the same collection sample, which may be ordered as a group. In most cases such as "Chem 7," the tests on the panel can also be ordered individually. 2) Also, a group of health care providers (HCPs) to which a family is assigned in a family practice clinic.
Parameters	Fixed limits or boundaries that establish by what restrictions the system will perform a function.
Patient Administration (PAD) Subsystem and Medical Services Accounting (MSA)	The PAD Subsystem facilitates the collection recording of patient information regarding the admission, disposition, and transfer of patients. This subsystem also manages ward and bed status within the medical treatment facility (MTF). A component of the PAD Subsystem, MSA focuses on the initiation and monitoring of patient billing. The United States Military Services provide health care for millions of patients each year. The goal of Defense Medical Information Management (DMIM) is to enable military MTFs and clinics to use CHCS to enhance the quality of health care delivery provided. With an increase in the number and diversity of tasks performed by medical personnel, as well as an expansion of health-related technology, an improved approach to the management of medical information was needed. CHCS meets this need.

Glossary (continued)

Term	Definition
	As an integrated, computer-based system, CHCS provides an automated online alternative to many manually implemented tasks (i.e., writing patient care orders, documenting medication administration, generating reports, etc.), thus significantly reduces potentially massive amounts of paperwork.
Patient Appointment and Scheduling Subsystem (PAS) of CHCS	This subsystem enables individual clinics or providers to control their own scheduling, booking, and appointments, and alerts other system users to potentially conflicting schedules.
Patient Category Code	Patient Category codes indicate patient type (i.e., Active Duty Enlisted Air Force, Civilian Employee, Naval Officer's Dependent).
Patient Identifying Data	Patient name, family member prefix/Social Security number (FMP/SSN), date of birth (DOB), and sex.
Patient Inquiry	The act of retrieving CHCS-stored data regarding a selected patient.
Patient Record	A collection of data relative to a patient (e.g., patient name, Social Security number, date of birth, etc.).
PCM Beneficiary	Patients are designated as case management when they require an exception provider for specialty care.
PCM Beneficiary Category	The beneficiary categories for the PCM enrollment mix are: Active Duty, Active Duty Family Member, Retiree, Retiree Family Member, Other. For the PCM enrollment mix, these beneficiary categories replace the MCP Patient Types.
Pending Appointment	See Order Status.
Pharmacy Subsystem of CHCS (PHR)	The PHR Subsystem provides a versatile drug reference library. It allows flexibility in ordering medications (i.e., by trade or generic name, by drug component, route of administration, etc.) and provides

Glossary (continued)

Term	Definition
	online information regarding drug-to-drug interactions.
Place of Care	A medical treatment facility (MTF) or non-MTF clinic in the Managed Care Program (MCP).
Postmaster	The user responsible for managing mail groups, users, bulletins, and mail system protocol. The postmaster job is an assigned MailMan position. The position is often, but not necessarily, filled by the system manager.
Power Switch	Located on the left side of the terminal, this switch is used to turn on the terminal.
Preadmission	The process of entering admission data into CHCS for a potential patient.
Preadmission Order	An order written in anticipation of a future admission date and time.
Prefix	The two-to-four-character namespace assigned to routines and globals, distinguishing applications.
Prescription	Used to refer to a drug, administration schedule, and instructions ordered for an outpatient.
Primary Care Manager (PCM)	A Managed Care Program (MCP) health care provider (HCP) who is assigned as a primary physician for a patient. The PCM may be either an individual provider or a group provider.
Primary Menu	A user's initial or starting menu.
Printer	May be referred to as a printer device or output device: **Shared Printer:** A printer that is available to two or more terminals or output devices.

Glossary (continued)

Term	Definition
	Line Printer: A printer that prints a line or more at a time. (Line printer speeds are expressed in lines per second [lps] and may be over 100 lines per second.) **Slave Printer:** A printer attached directly to a terminal and used to print from that terminal only.
Print Template	A set of field specifications that allow exact print formats and specified data records to be used when printing reports. This allows the use of the same print logic again and again.
Privilege(s)	The capabilities allowed within the database management system (DBMS) based on the level of protection specified for any process, file, or user.
Profile	A collection of administrative, scheduling, and appointment information applicable to a specific facility, division, clinic, and provider. Patient Appointment and Scheduling (PAS) profiles define the basic rules and instructions by which the facility, division, clinic, and provider provide care; and they provide the parameters that control the way the system processes data.
Prompt	1) A system-generated request for response. 2) A word or statement on the screen that tells the user what action needs to be taken or what information must be entered (i.e., Select Patient Name).

Glossary (continued)

Term	Definition
Provider	See Health Care Provider.
Provider Class	Description of provider groups such as nurse, social worker, or physician. Each provider class is linked to a signature class. Provider classes are medical treatment facility (MTF)-definable.
Provider Group	A provider group is one or more providers who have jointly negotiated an agreement to provide services to eligible beneficiaries. A provider group can have multiple individual providers, multiple places of care, and/or multiple agreements.
Pseudo SSN	A false system-generated Social Security number used in a patient data record when the real number is unknown.
Pull List	A list of all patients whose medical records must be pulled for a specified date.
Question Mark (?) Key	See Computer Control Keys.
Radiology Subsystem of CHCS (RAD)	The RAD Subsystem is designed to meet the functional requirements of the Radiology Department and Nuclear Medicine, including patient processing and room scheduling, defining and implementing site-specific radiology procedure requirements, work load statistics, and management reports.
Record Number	Also known as the record identifier number This is a unique sequential number assigned to each record within the Record Tracking functionality upon its creation. The record may be accessed by entering this number at any Select Record prompt.
Record Room	Location of patient records.
Record Tracking	The procedure for determining where records are physically located.

Glossary (continued)

Term	Definition
Region Code	The number assigned to the DOD region associated with a patient's DMIS ID as recorded in the DEERS database.
Registration	A registration must be completed on all patients, whether inpatient or outpatient, before CHCS can support any care or services rendered.
Reminder Notices	A form mailed to patients to remind them of upcoming appointments.
Requesting Location	A specific location within the medical treatment facility (MTF) from which the patient services are requested, i.e., a ward, clinic or other location, and receiving credit for the orders placed, and to which test results and orders will be sent.
Response	An action to be taken in response to a specific prompt generated by the CHCS System. (For instance, Enter Provider Name: **[variable data]**.) In CHCS documentation, a required response is identified by **FULL CAP BOLD** text.
Retrieve	1) The ability to review a patient's past medical history. 2) Process of retrieving historical patient data that has been archived.
<Return> Key	See Computer Control Keys.
Routing Card	A card attached to the medical record itself that is sent around with the record. This card indicates where the record is to go, based on the clinics in which that patient has appointments.
Schedules	An array of available time slots for a certain provider in a specified clinic for a specified date range.

Glossary (continued)

Term	Definition
Schedule Time Slot	A single time opening in a provider's template or schedule for a certain type of appointment. The slot has a beginning and an end time, and a maximum number of patients that can be seen during that period. This is also referred to as an appointment slot.
Screen	1) The part of the visual display terminal (VDT) that presents information sent from the computer or information typed on the keyboard. 2) This term is also used to describe a single display of information that takes up the whole screen.
Scroll Mode	The system's request for information, presented one prompt at a time. The bottom line on the screen is replaced with new information. The user moves between prompts using <Return>, or the up-arrow or down-arrow keys. See Screen Mode.
Search	The process of locating an unknown number of records, in one file, based on one or more user-specified criteria. **Null:** Used to determine fields that contain no entries. No value can be placed on the NULL condition. This is abbreviated with the letter N.
Search Criteria	The rules by which the system searches for information. In Patient Appointment and Scheduling (PAS), the items that the system uses to search for open schedule slots. Search criteria in Booking can be Dates, Provider, Time Range, Days of Week, Appointment Type, Clinic, Duration, or Specialty. A user must identify the specific value or parameter for each selected search criterion. The system tries to find open schedule slots that match the parameters for all selected search criteria.

Glossary (continued)

Term	Definition
Search Logic	Expressions that define the parameters of the search. Valid logic parameters are: **AND:** The system extracts a data record when all stated search conditions have been met. **NOT:** The system extracts a data record when none of the specified search conditions are met. **OR:** The system extracts a data record when any of the combined search conditions are met.
Search Parameter	In Patient Appointment and Scheduling (PAS), the specific value for a search criteria that the system uses to search for open schedule slots.
Secondary Menu	See Menu.
Security Checks	The system checks accessibility to CHCS as the user enters a series of codes (Username and Access/Verify codes).
Security Key	A code that relates to the ability to use a certain process. Some security keys are already defined in the system. Other security keys are defined by the system manager. The naming conventions and strategy for the use of these keys is determined at each facility. The system manager assigns security keys to users as appropriate for their use of CHCS.
Select	Function that defines how to decide what the value will be by selecting one from among two or more possible values. Select is used if the actual value that will exist when the data element is used cannot be precisely predicted.
<Select> Key	See Computer Control Keys.
Select Mark	A tilde (~) or asterisk (*) that appears when the <Select> key is pressed. This mark identifies a selected item on a list.

Glossary (continued)

Term	Definition
Select Window	In Patient Appointment and Scheduling (PAS), the middle section of the Search Criteria screen. The window lists items for user selection.
Service	A clinical specialty within a medical treatment facility (MTF).
SF558	Record of emergency room encounter information from arrival to disposition. This form contains patient demographics, specifics about the arrival, medical status, disposition information, and discharge instructions to the patient.
SF600	Record of an outpatient clinic visit. This form contains patient demographics, appointment information: date, time, location, appointment type, and sections for recording comments and patient vital signs.
<Shift> and <Lock> Keys	See Computer Control Keys.
Single Patient Booking	One or several appointments for one patient in one clinic.
Slot	See Appointment Slot.
Spacebar	See Computer Control Keys.
Spacebar, <Return>	See Computer Control Keys.
Space Character	A special character that does not have an associated graphic representation. It is displayed as the absence of any character, where one might otherwise appear.
Specialty	In Patient Appointment and Scheduling (PAS), a search criterion in Booking for which the parameter is a clinic service. The clinic specialty is identified in the clinic profile (for example, dental care, family practice, pediatrics).

Glossary (continued)

Term	Definition
Sponsor	Person who qualifies the patient for health care (e.g., active-duty father is the sponsor of the dependent patient daughter).
Sponsorship	The organization that entitles the patient to health care (e.g., Army, Navy, Dept. of Education, Veterans Administration, etc.).
Switch Divisions	The user process to switch to an alternate division from the default division, or back to the default division from an alternate.
System Manager (SYSMAN)	Used generically to describe functions that must be accomplished to support CHCS initialization and operation at each site where CHCS is installed. Functions include database administration, system security management, installation management, and telecommunications management.
Table	A list of available choices. A table displays when ?? is entered at a field that has a table connected to it. A table cannot be appended from the field, but must be set up through the appropriate menu options or through FileMan.
Target Audience	The audience for which the training is designed.
Template	1) A predefined structure that controls a data entry dialogue, a printed report format, a sort sequence of an output, or a series of search conditions. Templates may be used repeatedly by entering the assigned name in brackets [ ] at the appropriate prompt. 2) In Patient Appointment and Scheduling (PAS), an array of schedule slots governed by the rules entered in the profiles. Templates are linked to specific providers, but not to any particular date range.

Glossary (continued)

Term	Definition
Template ID	In Patient Appointment and Scheduling (PAS), a unique identifier for a particular template. It is recommended that the template ID include the following information: day, clinic, provider, and template type (master, temporary, etc.).
Terminal	A device used to enter and send information to the computer. The keyboard and screen are terminal components.
Terminal Digit	This is the last two digits of the sponsor's Social Security number (SSN), starting at 00 and ending with 99.
Time Range	A search criterion for which parameters indicate a begin and end time.
Troop Medical Clinic (TMC)	The Army term for an outpatient clinic designated for active-duty walk-in or sick-call patients.
Type-ahead	A setting in the User file that allows the user to type ahead of what the computer is actually reading. The computer stores the keystrokes and reads them at its own pace.
Unique Patient Identifier	A set of data elements that uniquely identifies a patient in the central patient database, composed of sponsor Social Security number and patient family member prefix.
Update	The addition, deletion or modification of existing data.
User	A person authorized by the medical treatment facility (MTF) to initiate a process in CHCS via a terminal. User authorization will be determined through the virtual memory system (VMS) and CHCS system security functions.

Glossary (continued)

Term	Definition
User Attributes	Characteristics or settings. User attributes, for example, include the settings for use of the system (e.g., type-ahead allowed, time-out setting, access authorization, etc.).
Username	See User Security.
Username/Password	User security checking at the virtual memory system (VMS) level. Codes provide user access to VMS files.
User Security	A series of codes that serves to protect the system from unauthorized users. These codes are checked when a user is accessing the system. Username and Access/Verify codes are the two levels of security checking. **Access Code:** This code, together with the verify code, is used in the logon process to identify a legitimate user and gain access to CHCS. The code is site-specific and established by the CHCS system manager. It usually cannot be changed by the individual user. **Username:** The first level of security checking and the first code entered into CHCS at logon. **Verify Code:** This code, together with the access code, is used in the logon process to identify a legitimate user and gain access to CHCS. The code is established by the CHCS system manager at the medical treatment facility (MTF) and may be changed by the individual user from the Edit User Characteristics option of the Secondary Menu. The code does not show on the screen when entered.
Users Manual	The Users Manual volumes for each subsystem provide information addressed primarily to the users of a particular subsystem. This user manual is available online (OLUM). The OLUM can be accessed from any prompt. Some sites may not load

Glossary (continued)

Term	Definition
	OLUM due to disk space limitations; the CHCS Training Database contains the MailMan volume only.
User-Specified	Parameters input by the user at the time the function is being called/executed.
Validity Check	CHCS utility that determines data inconsistencies gathered during the registration process (e.g., entry of an Air Force patient category for a Navy patient, fields left blank with no entry, etc.).
Viewgraphs	Viewgraphs, also called transparencies, are diagrams or text reproduced on transparent material used for projecting information on a screen.
Virtual Memory System (VMS)	The operating system that runs the VAX computer. It manages the memory of the computer in such a way that the memory appears to be virtually unlimited to the average user.
Wait List	All Wait List requests for a particular clinic. The clinic Wait List identifies those patients waiting for open schedules slots for that clinic. The clinic profile indicates whether a specific clinic has a Wait List. This allows the entry of Wait List requests for that clinic.
Wait List Request	A patient request for an appointment in a specific clinic when no open slots or overbooks are available in a certain clinic.
Ward	A defined hospital area that contains a designated number of patient beds. It often corresponds to a medical specialty area such as Orthopedics (e.g., Orthopedics Ward).
Word Processing Data Type	See Data Type.

Glossary (continued)

Term	Definition
Workcenter	A functional or organizational subdivision of a medical treatment facility (MTF) for which provision is made to accumulate and measure expenses and to determine workload performance. Designation of a workcenter varies from facility to facility depending upon the MTF organizational structure. CHCS workcenters include clinics used in Patient Appointment and Scheduling (PAS), pharmacies, laboratories, and radiology imaging locations.
Workload/MEPRS Reports	Quality control reports containing statistics and management data generated by the system to monitor specific military and medical treatment facility (MTF) workload statistical reporting requirements.
Zip Code Combination	A name that represents a range of zip codes. This site-definable name can be used during Managed Care Program (MCP) provider searches.

Glossary (continued)

Term	Definition
ACV	Alternate Care Value
ADT	Admission, Disposition, and Transfer
AHP	Allied Health Professional
AQCESS	Automated Quality of Care Evaluation Support System
ASAP	As Soon As Possible
ASMRO	Armed Services Medical Regulatory Office
AWOL	Absent Without Leave
BC/BS	Blue Cross/Blue Shield
CAS	Central Appointments Service
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHCS	Composite Health Care System
CSU/DSU	Channel Service Unit/Data Service Unit
DEA	Drug Enforcement Administration
DEERS	Defense Enrollment Eligibility Reporting System
DOB	Date of Birth
DOD	Department of Defense
DRT	Delinquent Record Tracking
DTS	Dietetics Subsystem of CHCS
DWC	Divided Workcenter

Glossary (continued)

Term	Definition
EAS	Expense Assignment System
ER	Emergency Room
ERD	Emergency Room Death
FI	Fiscal Intermediary
FileMan	File Manager
FMP	Family Member Prefix
FQA	Facility Quality Assurance of CHCS
HCF	Health Care Finder
HCP	Health Care Provider
HCP-ID	Health Care Provider Identification
HMO	Health Maintenance Organization
Ht	Height
ID	Identification
IEN	Internal Entry Number
INIT	Initialization
IP	1) Inpatient 2) Internet Protocol
JCAHO	Joint Commission on Accreditation of Health Care Organizations
KVDT	Keyboard Video Display Terminal
LAB	Laboratory Subsystem of CHCS

Glossary (continued)

Term	Definition
LAYGO	Learn As You Go
MailMan	Mail Manager
MAR	Medication Administration Record
MCP	Managed Care Program
MEPRS	Medical Expense and Performance Reporting System
MSA	Medical Services Accounting
MSAO	Medical Services Accounting Office
MTF	Medical Treatment Facility
MTRC	Medical Treatment Record Card
MUMPS	Massachusetts General Hospital Utility Multi-Programming System
MVVR	Master Version Validation Report
N	1) No 2) Variable number
NAS	Non-Availability Statement
NEC	Not Elsewhere Classified
OCONUS	Outside the Continental United States
OCR	Optical Character Reader recognition
OHI	Other Health Insurance
OHMIS	Occupational Health Management Information System
OLUM	Online Users Manual

Glossary (continued)

Term	Definition
OP	Outpatient
OSA	Only Service Available
PAD	Patient Administration Subsystem of CHCS
PAD MSA	PAD Medical Services Accounting Subsystem of CHCS
PAS	1) Patient Appointment and Scheduling Subsystem of CHCS 2) PAS Order
PATCAT	Patient Category
PCM	Primary Care Manager
PCS	Permanent Change of Station
PEB	Physical Evaluation Board
PHR	Pharmacy Subsystem of CHCS
PNT,PT	Patient
PRP	Personal Reliability Program
PTF	Patient Treatment File in DHCP
PTID	Patient Identifier Number (FMP/SSN)
QA	Quality Assurance
RAD	1) Radiology Subsystem of CHCS 2) RAD Order

Glossary (continued)

Term	Definition
RX	1) Outpatient medication 2) Receive
SAIC	Science Applications International Corporation
SDSMGR	PAS Scheduling Manager
SSN	Social Security Number
STD	Standard
SW	Software
SYSMAN	System Manager
T	1) In the context of a data value that is expected to refer to a date, FileMan interprets the letter "T" to mean the date of the current day (i.e., Today). 2) Temperature
TBD	To Be Determined
TDB	Training Database
TMC	Troop Medical Clinic
UCI	User Class Identifier
UPIN	Unique Physician Identification Number
UR	Utilization Review
VAX	Virtual Address Extension
VT320 Terminal	The CHCS terminal used in most workstation configurations

Glossary (continued)

Term	Definition
WAM	Workload Assignment Module
WCS	Workcenter Support
Y	Yes
Y/N	Yes/No

CHCS: MCP DESKTOP USER GUIDE

Appendix C
Medicare Demonstration

Appendix C. Medicare Demonstration

C.1 MEDICARE DEMONSTRATION OVERVIEW

The Medicare Demonstration project incorporates a variety of enhancements to CHCS Version 4.5 to track Medicare patients' MCP enrollments at approved sites. The Medicare enhancements were deployed to the selected sites as a special release to CHCS Version 4.5. These enhancements have since been incorporated into CHCS Version 4.6 for release to all sites.

Medicare patients are assigned the Alternate Care Value (ACV) of D. For patients with an ACV of D, enrollment transactions are transmitted to the Defense Enrollment Eligibility Reporting System (DEERS) whether the enrolling site is operating in DEERS Enrollment mode or Local Empanelment mode.

C.2 BUSINESS RULES

- Enrollment related transaction processing for Medicare enrollees follows existing processing and discrepancy resolution activities. Site personnel are responsible for monitoring enrollment discrepancies for all enrollees.

- In CHCS Version 4.5, the Local Empanelment mode transmits enrollment transactions for Active Duty enrollees. With Medicare Demonstration enhancements, the local Empanelment parameter transmits enrollment transactions to DEERS for MCP Patient Types, Active Duty and Medicare.

- The default enrollment end date logic (three years after enrollment start date) implemented with the Medicare Demonstration effort, does NOT apply to sites operating in Regions 13 and 14.

C.3 TOPICS

- Cancel Medicare enrollments
- Utilize current eligibility information
- Transmit enrollment-related transactions when in local empanelment mode
- Changes to enrollment mode
- Default of enrollment end date for Medicare enrollees
- ASCII File data for Medicare enrollees

C.3.1 Cancel Medicare Enrollments

Sites participating in the Medicare Demonstration program must disenroll or cancel all CHCS Medicare enrollments. Anticipating the Medicare Demonstration project, Electronic Data Systems (EDS) has canceled or disenrolled all Medicare enrollments from the DEERS database

After installing the Medicare Demonstration enhancements run a data clean-up to verify that all Medicare enrollments have been canceled or disenrolled at each participating CHCS site. If a site has Medicare enrollees, the clean-up automatically cancels the enrollments in CHCS. Because Medicare enrollments have been cleared from the DEERS database, cancellation transactions are not transmitted to DEERS.

After the clean-up, a report identifies current Medicare enrollment patients whose enrollment was canceled as part of the Medicare Demonstration. The patient name, Family Member Prefix (FMP)/Social Security number (SSN), enrollment start date, and original enrollment end date displays on this report. The data is sorted by sponsor SSN. If there are 50 or more patient records canceled by this process, a report footer requests that the site file a SAIC Support Call for development team analysis.

Refer to Figure CC-11. Canceled Enrollments for Medicare Enrollees Report.

```
                Canceled Enrollments for Medicare Enrollees

FMP/SSN:         NAME:                   ENROLL START     ENROLL END:
-------------------------------------------------------------------------

20/043-30-2221   BROWN,THOMAS            01 Jun 96        31 Dec 97
30/043-30-2221   BROWN,CANDACE E         01 Jun 96        31 Dec 97
31/122-22-1887   ADAMS,SANDY             01 Feb 97        31 Jan 98
.
.
.
30/801-44-6543   DONOVAN,SUSAN T         08 Jan 97        31 Jan 98
-------------------------------------------------------------------------

TOTAL MEDICARE ENROLLEES CANCELED:  59


* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *
NOTE:
Based on the number of Medicare enrollments that were canceled upon
installation, please file a SAIC Support Call. MCP software development staff
must review the data contained in this report. The installation of the
Medicare demonstration enhancements will not be impacted by the generation of
this report.
```

Figure C-1. Canceled Enrollments for Medicare Enrollees Report

C.3.2 Utilize Current Eligibility Information

Menu Path: PAS System Menu → M → EMCP → EENR

CHCS Version 4.5 MCP enrollment functionality uses various CHCS data elements to project the MCP Patient Type, which is used to transmit the ACV. If the patient is 65 years or older, the system automatically defaults the Patient Type of Medicare. CHCS Version 4.5 does not use data received from DEERS through an eligibility response.

The Medicare Demonstration enhancements include an additional check to use data from a current eligibility response. Eligibility data is considered current if received within the last five days. If the CHCS patient is age 65 or older, the system uses the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) eligibility data if the response is current. If the CHAMPUS field indicates Not Eligible or is Null and the patient is 65 or older, the system defaults the Patient Type to Medicare and the ACV of D is transmitted to DEERS for all enrollment transactions. If no current eligibility check is on file, only the patient's age in

CHCS is used to determine if the patient is Medicare eligible. The patient Type can be edited if appropriate.

> **Note:** The CHCS/DEERS interface must be operational to receive a current eligibility response.

C.3.3 Transmit Enrollment-Related Transactions when in Local Empanelment Mode

Menu Path: PAS System Menu → M → FMCP → FTAB → PARA

Whether a site operates in Local Empanelment mode or DEERS Enrollment mode, the system transmits the following DEERS enrollment transactions for Medicare enrollees (ACV=D):

Code	Activity
AQC40	Enrollment Cancellation
AQC41	Enrollment
AQC42	Disenrollment
AQC43	Reciprocal Disenrollment
AQC44	Reciprocal Disenrollment/Enrollment
AQC45	Enrollment Start Date Update
AQC46	Enrollment End Date Update
AQC47	Enrollment DMIS ID/PCM Location Code Update
AQC48	Enrollment End Date Cancellation
AQC5J	Reciprocal Disenrollment (from losing site)

C.3.4 Changes to Enrollment Mode

Menu Path: PAS System Menu → M → FMCP → FTAB → PARA

The MCP Parameter option includes additional prompts if the site changes the Enrollment Mode to or from DEERS Enrollment/Local Empanelment mode. Family members of active duty enrollees and family members of retired enrollees must be disenrolled when this field in the MCP Parameter option is changed. Medicare enrollees are a subset of non-active duty; however, the site may now choose not to disenroll Medicare patients when the enrollment parameter is changed. If you choose to disenroll Medicare patients, disenrollment transactions are not sent to DEERS and the MCP status on the CHCS local system is updated to Disenrolled.

> **Note:** Only users that hold the CPZ PARAMETERS key have the ability to change enrollment modes.

Refer to Figure CC-22. MCP Parameters Screen.

```
Catchment Area Name:  MCP DIVISION
Catchment Area DMIS ID:  6501

                                        Enrollment Mode:  LOCAL EMPANELMENT

           Restrict Enrollment by Residential Address:  NO
    Restrict Enrollment for Active Duty Family Members:  NO
         Restrict Enrollment for Retired Beneficiaries:  NO
        Restrict Enrollment for Retired Family Members:  NO

                   Hours for running Batch Enrollment:  2100 to 0400

              Active Duty DEERS Eligibility Parameters:

             Date to Perform Annual Eligibility Checks:  05 Oct
    Day of Month to Perform Monthly Eligibility Checks:  2

All non-active duty MCP Enrollees/Empanelees must be disenrolled prior to
changing the Enrollment Mode.

Do you wish to Disenroll/Disempanel all Medicare enrollees? Y

Do you wish to Disenroll/Disempanel all remaining non-active duty MCP
Enrollees? Y
```

Figure C-2. MCP Parameters Screen

C.3.5 Default of Enrollment End Date for Medicare Enrollees

Menu Path: PAS System Menu → M → EMCP → EENR

The system defaults an enrollment end date of three years from the enrollment start date for Medicare enrollees. You can override the default if required by entering any other date prior to the default date.

> **Note:** The enrollment end date default does not apply to sites in Regions 13 and 14.

C.3.6 ASCII File Data for Medicare Enrollees

A utility has been developed to extract data required by systems external to CHCS (e.g., HEAR, CCHI, ID Cards). Specifically, this utility extracts historical, current, and future enrollments for enrollees with the ACV of D after 1 May 1997. There are no date range prompts. Using the Managed Care Program (MCP) status, users can identify or screen enrollees based on the desired MCP status.

You must have programmer access to generate this American Standard Code for Information Interface (ASCII) file. Records are sorted in alphabetical order by patient name with each record delimited with the character '<CR>'. Data elements within a record are delimited with the '^' character. The subsections list the following four types of ASCII file data elements.

C.3.6.1 Patient-Related Information

- Name
- FMP/SSN
- DOB
- Sex (Code)
- Address 1
- Address 2
- City
- State (Code)
- ZIP

C.3.6.2 Sponsor-Related Information

- Sponsor Name
- Sponsor SSN
- Sponsor DOB
- Address 1
- Address 2
- City
- State (Code)
- ZIP
- Sponsor Phone #
- Branch of Service (Code)
- Rank (Description)
- Paygrade (Description)
- Patient Category (Code)
- Sponsor Status (Description)

C.3.6.3 DEERS-Related Information

- DDS (Code)
- DEERS Alt Care Flag (Code)
- Direct Care Eligibility (DESC)
- DMIS ID
- PCM Location (Code)
- DEERS Sponsor Status (Code)
- Medicare Eligibility (DESC)
- CHAMPUS (Description)
- DEERS Eligibility End Reason (Description)

C.3.6.4 Enrollment-Related Information

- Enroll Start Date
- Enroll End Date
- Alternate Care Value
- MCP Status
- Disenroll Reason (DESC)
- Division (DMIS ID)
- PCM Name
- PCM Address
- PCM City
- PCM State (Code)
- PCM ZIP
- PCM Phone
- PCM FAX
- Contractor PCM Location (Code)
- PCM Identifier

CHCS: MCP DESKTOP USER GUIDE

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